COMMUNITY HOSPITAL NORTH

INDIANAPOLIS, INDIANA

APPLICATION

FOR

"IN THE ACS VERIFICATION PROCESS"

LEVEL III TRAUMA CENTER DESIGNATION

JULY 8, 2014

APPLICATION FOR HOSPITAL TO BE DESIGNATED "IN THE ACS VERIFICATION PROCESS"

State Form 55271 (5-13)

Date submitted *(month, day, year)*
07/08/2014

APPLICANT INFORMATION		
Legal name Community Hospital North		
Mailing address *(number and street, city, state, and ZIP code)* 7150 Clearvista Dr Indianapolis, IN 46256		
Business telephone number (317) 621-5342	24-hour contact telephone number [redacted]	Business fax number [redacted]

CHIEF EXECUTIVE OFFICER INFORMATION	
Name Jason Fahrlander	Title President
Telephone number [redacted]	E-mail address [redacted]
TRAUMA PROGRAM MEDICAL DIRECTOR INFORMATION	
Name Joseph Pavlik, M.D., F.A.C.S	Title Trauma Medical Director
Telephone number [redacted]	E-mail address [redacted]
TRAUMA PROGRAM MANAGER INFORMATION	
Name Karen Hagen RN, CEN, CPEN	Title Trauma Program Manager
Telephone number [redacted]	E-mail address [redacted]

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 Jason Fahrlander	Date *(month, day, year)* 07/08/2014
Signature of trauma medical director	Printed name Joseph Pavlik, M.D.	Date *(month, day, year)* 07/08/2014
Signature of trauma program manager Karen Hagen	Printed name Karen Hagen, RN	Date *(month, day, year)* 07/08/2014

INSTRUCTIONS: Address each of the attached in narrative form

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

Community Hospital North 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 Indiana State Trauma Care Committee and the Indiana EMS Commission with complete documentation supporting our designation request.

Community Hospital North has been an integral part of the Northeast region of Indianapolis Trauma Care. 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 pursue American College of Surgeons verification as a Level III Trauma Center within two calendar years.

Respectfully,

Jason Fahrlander
President, Community Hospital North

Joseph Pavlik, M.D., FACS
Trauma Medical Director

APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL I 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 I 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 full-time 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 on call**: The surgeon must be dedicated to the trauma center while on call. Supporting documentation for this requirement must also include a written letter of commitment signed by all surgeons of the hospital that the scheduled Trauma Surgeon will be dedicated to the trauma center. There must also be evidence provided that a Trauma Surgeon is a member of the hospital's disaster committee. A roster of the membership of the disaster committee must be provided.

7. **Trauma Surgeon response times**: Evidence must be submitted that response times for the Trauma Surgeon are fifteen (15) minutes maximum, tracked from patient arrival at the hospital, and must be compliant at least eighty percent (80%) of the time, as defined by the Optimal Resources document of the American College of Surgeons. A published back-up schedule for trauma surgery must also be available and provided as part of the documentation. Also, there must be a written letter of commitment to the center's Trauma Surgeon response times, signed by the Trauma Medical Director, that is included as part of the hospital's application.

8. **In-house Emergency Department physician coverage**: There must be 24-hour-per-day, 365-days-per-year, 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.

9. **Orthopedic Surgery**: There must be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, that Orthopedic Surgery team members have dedicated call at the hospital. There must also be a back-up Orthopedic Surgery call schedule that is provided as part of this application.

10. **Neurosurgery**: Neurosurgery must be promptly available twenty four (24) hours per day for severe traumatic brain injury and spinal cord injury, as well as for less severe head and spine injuries. A back-up call schedule must also be available with formally arranged contingency plans in case the capability of the neurosurgeon, hospital or system to care for neurotrauma patients is overwhelmed. The documentation must include a letter of commitment signed by neurosurgeons and the Trauma Medical Director that neurosurgeons are available to the trauma center twenty four (24) hours per day.

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 hospital must have an in-house trauma team and the OR must be immediately available. 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. Level I trauma centers must have 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. Level I trauma centers must show documentation of multiple CT scan machine capabilities and a written letter of commitment from the hospital's Chief of Radiology.

14. **Interventional radiology**: There must be twenty four (24) hour availability of interventional radiology (conventional catheter angiography and sonography) and a written letter of commitment signed by the Chief of Radiology.

15. **Intensive care unit**: There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources that include intracranial pressure monitoring equipment to resuscitate and monitor injured patients, all of which are available twenty four (24) hours per day.

16. **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. The facility must also have the capability for coagulation studies, blood gases, and microbiology twenty four (24) hours per day.

17. **Laboratory services**: There must be laboratory services available twenty four (24) hours per day for the standard analyses of blood, urine and other bodily fluids, including micro-sampling when appropriate.

18. **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.

19. **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.

20. **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.

21. **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.

22. **Nurse credentialing requirements**: Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department, ICU and PACU.

23. **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 I 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.

APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL II 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 II 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 full-time 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 on call**: The surgeon must be dedicated to the trauma center while on call. Supporting documentation for this requirement must also include a written letter of commitment signed by all surgeons of the hospital that the scheduled Trauma Surgeon will be dedicated to the trauma center. There must also be evidence provided that a Trauma Surgeon is a member of the hospital's disaster committee. A roster of the membership of the disaster committee must be provided.

7. **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. A published back-up schedule for trauma surgery must also be available and provided as part of the documentation. Also, there must be a written letter of commitment to the center's Trauma Surgeon response times, signed by the Trauma Medical Director, that is included as part of the hospital's application.

8. **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.

9. **Orthopedic Surgery**: There must be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, that Orthopedic Surgery team members have dedicated call at the hospital. There must also be a back-up Orthopedic Surgery call schedule that is provided as part of this application.

10. **Neurosurgery**: Neurosurgery must be promptly available twenty four (24) hours per day for severe traumatic brain injury and spinal cord injury, as well as for less severe head and spine injuries. A back-up call schedule must also be available with formally arranged contingency plans in case the capability of the neurosurgeon, hospital or system to care for neurotrauma patients is overwhelmed. The documentation must include a letter of commitment signed by neurosurgeons and the Trauma Medical Director that neurosurgeons are available to the trauma center twenty four (24) hours per day.

11. **Trauma Operating room, staff and equipment**: There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed and readily available 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. Level II trauma centers must have 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. Level II trauma centers must show documentation of multiple CT scan machine capabilities and a written letter of commitment from the hospital's Chief of Radiology.

14. **Interventional radiology**: There must be twenty four (24) hour availability of interventional radiology (conventional catheter angiography and sonography) and a written letter of commitment signed by the Chief of Radiology.

15. **Intensive care unit**: There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources that include intracranial pressure monitoring equipment to resuscitate and monitor injured patients, all of which are available twenty four (24) hours per day.

16. **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. The facility must also have the capability for coagulation studies, blood gases, and microbiology twenty four (24) hours per day.

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

17. **Laboratory services**: There must be laboratory services available twenty four (24) hours per day.

18. **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.

19. **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.

20. **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.

21. **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.

22. **Nurse credentialing requirements**: Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department, ICU and PACU.

23. **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 II 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.

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.

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.

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 North

Indianapolis, Indiana

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

SECTION 1

Trauma Medical Director

"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."

NARRATIVE RESPONSE AND DISCUSSION

The requirements of section 1 include a letter from Dr. Joseph Pavlik, the Community Hospital North Trauma Medical Director. Dr. Pavlik is a Board-Eligible Physician who will be re-examining in November of 2014. Dr. Pavlik is currently registered for an ATLS course in Minneapolis, MN July 8th & 9th and documentation of completion will be sent to the ISTCC when received. Dr Pavlik participates in General Surgery call and is solely dedicated to administration of the Community North Trauma Program. The role summary for the Trauma Medical Director is attached.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this letter is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital North in the effort to complete the "in the process Level III Trauma Center requirements. We are committed to working together to provide 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 regards to the ATLS certification requirement of the Medical Director I am scheduled to attend a course July 8th & 9th in Minneapolis, MN.

Respectfully,

Joseph Pavlik,M.D.,FACS
Trauma Medical Director

HR USE ONLY
Position Code: 005063
Employee Type: Salary
Effective Date: March 2014
Developed By:
HR Consultant: S Pearcy

TITLE: Trauma Medical Director

DEPARTMENT AND COST CENTER: Trauma Program – 67803

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: Medical Doctor, Board Certified Surgeon

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

PREREQUISITE 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 solving make decisions
- Demonstrated history of positive collegial relations with colleagues, support staff, hospital-based providers, administrators and patients. Identify what skills are necessary to do this job; e.g., typing WPM

SKILLS TESTING:	Identify any skills testing that is required for the position, e.g., typing, filing, data entry, grammar, basic math, etc.
REPORTS TO:	VP of Clinical Performance / President of Medical Staff / Executive Vice President
SUPERVISES:	None

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 organization 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 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.
• Maintains the privacy and security of protected health information (PHI), the confidentiality of all information, and conducts 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.
• Maintain required CME's

PHYSICAL/ENVIRONMENTAL

REQUIREMENTS: Please see check list

Knowledge/Physical Requirements

WORK-PLACE ACTIVITIES*

* Frequencies based on DOT (Dictionary of Occupational Titles) standard frequencies

Activity		Never 0% of the day 0 per day 0		Occasional 1-33% of day 1-66 per day 1 per 15 min.		Frequent 34-66% of day 67-200 per day 1 per 5 min.		Constant 67-100% of day 200 plus per day 1 per 30 sec.
Standing						x		
Sitting				x				
Walking						x		
Bending						x		

Forward						x		
Sideways						x		
Climbing				x				
Grasping				x				
Pushing (Carts, wheelchairs, etc)				x				
Pulling (Carts, wheelchairs, etc)				x				
Twisting at waist				x				
Work above shoulders				x				
Repetitive arm movement				x				
Reaching				x				
Overhead:				x				
Forward:				x				
Side:				x				
Rear:				x				
Squatting				x				
Kneeling				x				
Crawling				x				
Wrist & Forearm				x				
Pronation / Supination				x				
Nondependent patient transfers				x				
Dependent patient transfers				x				
May drive between worksites				x				

Lifting and Carrying		**Never**		**Occasional**		**Frequent**		**Constant**
Under 10 lbs						x		
10-20 lbs				x				
20-30 lbs				x				
30-40 lbs				x				

Joseph J. Pavlik, M.D., FACS

Joseph J. Pavlik, M.D., attended Wabash College in Crawfordsville, Indiana. He received his medical degree from Indiana University School of Medicine in Indianapolis. He completed a residency at University of Cincinnati Hospitals in Cincinnati, Ohio.

Dr. Pavlik is board certified in general surgery. He specializes in abdominal surgery, hernias, biliary (gallbladder) surgery and pancreatic surgery. He performs laparoscopic surgery with a focus on spleen, pancreas, colon and hernias. He treats patients of all ages.

He is a member of the Indiana State Medical Association, and a Fellow of the American College of Surgeons.

Dr. Pavlik is married and the father of three teenagers. In his spare time, he enjoys hockey and is a high-performance driving instructor.

2014 ATLS Course Information

The 2014 Hennepin County Medical Center Advanced Trauma Life Support (ATLS) courses are scheduled as follows:

☐ January 23 & 24, 2014	Thursday - Friday, 7:30am - 5pm
☐ March 11 & 12, 2014	Tuesday - Wednesday, 7:30am - 5pm
☐ May 5 & 6, 2014	Monday - Tuesday, 7:30am - 5pm
☐ July 8 & 9, 2014	Tuesday - Wednesday, 7:30am - 5pm
☐ October 2 & 3, 2014	Thursday – Friday, 7:30am – 5pm

The course fee is $850 payable in advance. This fee includes the textbook and meals. (Auditor fee is $250.00.) You can expect to receive a course packet 2-4 weeks before the course. The following policy applies if we are unable to fill your space due to your cancellation. Cancellation within 2-4 weeks of the course will result in retention of ½ the course fee. Cancellation within 2 weeks or no-shows will result in retention of the entire fee.

ATLS courses fill quickly. Before mailing this form, please call at (612) 873-9147 to verify available space. You may also request to be placed on the wait list for any course that is filled.

ATLS Course Registration

Name: Joseph Pavlik, MD (Participant / Auditor – Please circle)
Please include your title, e.g., M.D., PA-C, NP, CRNA

Street Address: 8040 Clearvista Pkwy #240

City: Indpls State: IN Zip code: 46250

Daytime Telephone: [redacted] ger/Cell: (__)___-____

Email Address (*required*): [redacted]

Hospital/Clinic Affiliation: Community Health Network

Medical Specialty: General Surgery

Resident? Yes (No)

Payment Options:

Type of Card: Visa Name as it appears on card: Amy Dodd

Credit card number [redacted] Exp. Date 5/12 Signature Code [redacted]

Checks must be made payable to **HCMC EMS EDUCATION**

Return this completed form to:

ATLS Program
EMS Education MC 825
Hennepin County Medical Center
701 Park Avenue South
Minneapolis, MN 55415
Fax: 612-904-4537
susan.altmann@hcmed.org

Community Hospital North

Indianapolis, Indiana

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

SECTION 2

Trauma Program Manager

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

NARRATIVE RESPONSE AND DISCUSSION

Karen Hagen, RN [redacted] is the Community Hospital North Trauma Program Manager. The role summary of the position is included in this section. Karen maintains and is current in her Trauma Nursing Core Course (TNCC) certification, ACLS, and PALS. Karen also has her Certification in Emergency Nursing (CEN) and Pediatric Emergency Nursing (CPEN).

HR USE ONLY

Position Code: 005062
Employee Type: Hourly
Effective Date: 03.17.14
Developed By: ED Department Directors
HR Consultant: S Pearcy

TITLE:	Trauma Program Manager
DEPARTMENT AND COST CENTER:	67803CHN
ROLE OVERVIEW:	The Trauma Program Manager is responsible for the development, implementation and evaluation of systems and programs at Community Hospitals directed toward the provision of quality services for trauma patients from a multidisciplinary perspective throughout the continuum of care. This structure of care for the injured patient is a collaborative effort from all departments that make up the trauma response team.
REQUIRED EXPERIENCE:	Three years clinical experience in the care of injured patients. Previous involvement with trauma certification and data collection.
REQUIRED EDUCATION:	Graduate of an approved nursing program **required,** BSN preferred. **Or** Bachelor's degree with Clinical License (i.e. LPN or Paramedic) w/ 2 years leadership experience & 3 years clinical experience **required.**
REQUIRED LICENSE:	Current Indiana license required (i.e. RN, LPN, Paramedic) Current ACLS certification w/in 6 months TNCC and ATCN w/in 18 months, if RN
PREREQUISITE SKILLS:	Educational preparation and clinical experience in the care of injured patients.
SKILLS TESTING:	None
REPORTS TO:	Chief Nursing Officer / Executive Vice President or designee

SUPERVISES: Trauma Registrar

ESSENTIAL FUNCTIONS:

Clinical:

- Assure compliance with the American college of Surgeons and the Indiana State Department of Health standards for the optimal care of the injured patient.
- Help facilitate future strategic goals as a trauma center geared toward excellence and high standards of care.
- Coordinate trauma care management across the continuum of care.
- Coordinate with physicians, nurses and other hospital staff to evaluate and address specific patient care issues.
- 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 current literature, input from clinicians and other sources, such as information from the trauma peer review process.

Education:

- Provide for intra-facility staff development; participate in case review, implement practice guidelines, and direct community trauma education and prevention programs.
- Performance Improvement:
- Participate in case reviews and trauma rounds.
- Monitor clinical outcomes.
- Monitor system issues related to quality of care delivery.
- Develop quality filters, audits and case reviews.
- Identify trends and sentinel events.
- Assist in the development, implementation and evaluation of a quality plan that is multidisciplinary and focused on patient outcomes.

Administrative:

- Represent the Trauma Program on various hospital and State committees to enhance and foster optimal trauma care management.
- Manage, as appropriate, the operational, personnel and financial aspects of the Trauma Program.
- Supervise adherence to hospital policies, procedures and standards through observation, medical record review, staff feedback and other appropriate sources.
- Trauma Registry:
- Review the collecting, coding, scoring and developing of processes for validation of data entered into the trauma registry.

- Design the registry to facilitate performance improvement activities, trend reports and research, while protecting confidentiality.
- Maintains a minimum of 16 hours of trauma-related continuing education per year and clinical experience in the care of injured patients

EMS/Emergency Management:

- Work with EMS Director and the Audit & Review Committee to review trauma education needs of the EMS agencies.
- Participates on the Hospital Emergency Preparedness Committee and collaborates with District 5 Emergency Preparedness Committee to achieve goals and deliverables.
- 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.

COMPETENCIES: Hospital / Network mandatory competencies

PHYSICAL/ENVIRONMENTAL REQUIREMENTS: Please see check list

WORK-PLACE ACTIVITIES*

* Frequencies based on DOT (Dictionary of Occupational Titles) standard frequencies

Activity		Never 0% of the day 0 per day 0		Occasional 1-33% of day 1-66 per day 1 per 15 min.		Frequent 34-66% of day 67-200 per day 1 per 5 min.		Constant 67-100% of day 200 plus per day 1 per 30 sec.
Standing				x				
Sitting						x		
Walking				x				
Bending				x				
Forward				x				
Sideways				x				
Climbing				x				
Grasping				x				
Pushing (Carts, wheelchairs, etc)				x				
Pulling (Carts, wheelchairs, etc)				x				
Twisting at waist				x				

Work above shoulders				x				
Repetitive arm movement						x		
Reaching				x				
Overhead:				x				
Forward:				x				
Side:				x				
Rear:				x				
Squatting				x				
Kneeling				x				
Crawling				x				
Wrist & Forearm								
Pronation / Supination						x		
Nondependent patient transfers				x				
Dependent patient transfers				x				
May drive between worksites				x				

Lifting and Carrying		**Never**		**Occasional**		**Frequent**		**Constant**
Under 10 lbs						x		
10-20 lbs				x				
20-30 lbs				x				
30-40 lbs				x				

Board of Certification for Emergency Nursing

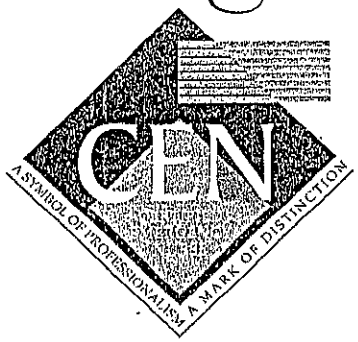
Hereby certifies that

Karen Caldarella

having successfully met the qualifications

has attained the designation of

Certified Emergency Nurse



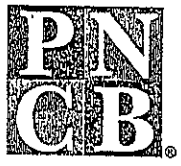
C. Lynne Grief, PhD, RN, CEN
BCEN Chairperson

1/7/2017
Expiration date

[redacted]
Certification number

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

Board of Certification for Emergency Nursing and Pediatric Nursing Certification Board



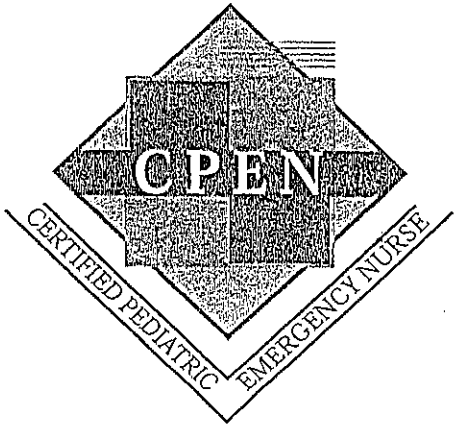
hereby states that

KAREN RENEE CALDARELLA

has successfully met the qualifications and competencies of the

Certified Pediatric Emergency Nurse

Chairperson, Board of Certification for Emergency Nursing



President, Pediatric Nursing Certification Board

[redacted]
Certification Number

April 18, 2011
Initial Certification Date

PEDIATRIC ADVANCED LIFE SUPPORT

American Heart Association | American Academy of Pediatrics

PALS Provider

Karen R Hagen

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Pediatric Advanced Life Support (PALS) Program.

04-23-2014 — Issue Date

04-2016 — Recommended Renewal Date

HEALTHCARE PROVIDER

Healthcare Provider

American Heart Association

Karen R. Hagen

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association BLS for Healthcare Providers (CPR and AED) Program.

05-30-2014 — Issue Date

05-2016 — Recommended Renewal Date

ENA EMERGENCY NURSES ASSOCIATION 915 Lee Street • Des Plaines, IL • 60016-6569

Karen Hagen — Name

June 6, 2018 — Expiration Date

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

Teresa L. Will RN — Course Director

ADVANCED CARDIOVASCULAR LIFE SUPPORT

ACLS Provider

American Heart Association

Karen R. Hagen

This card certifies that the above individual has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Advanced Cardiovascular Life Support (ACLS) Program.

04-30-2014 — Issue Date

04-2016 — Recommended Renewal Date

ADVANCED CARDIOVASCULAR LIFE SUPPORT

Training Center Name: Community Health Network Clinical Education — TC ID # [redacted]

TC Info: 1500 N Ritter Ave. City: Indianapolis, IN 46219 — TC Phone: 317-355-4885

Course Location: Community Heart & Vascular

Instructor Name: Lynnett Doyle [redacted] Inst. ID #

Holder's Signature: Karen Hagen

© 2011 American Heart Association *Tampering with this card will alter its appearance.* 90-1805

HEALTHCARE PROVIDER

Training Center Name: Community Health Network Clinical Education — TC ID [redacted]

TC Info: 1500 N Ritter Ave. City: Indianapolis, IN 46219 — TC Phone: 317 355-4885

Course Location: Community Heart & Vascular

Instructor Name: Susan E. Taylor [redacted] Inst. ID #

Holder's Signature: Karen Hagen

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PEDIATRIC ADVANCED LIFE SUPPORT

Training Center Name: Community Health Network Clinical Education [redacted]

TC Info: 1500 N Ritter Ave. City: Indianapolis, IN 46219 — TC Phone: 317 355-4885

Course Location: Community Hospital East

Instructor Name: Teresa L. Will [redacted] Inst. ID #

Holder's Signature: Karen Hagen

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SOCIETY OF TRAUMA NURSES

Continuing Education Certificate

This certifies that

Karen Hagan RN

has attended and successfully completed:

Optimal Trauma Center Organization and Management Course

and is hereby awarded

6.2 contact hours

Wednesday, October 11, 2013
Indiana State Department of Health
Indianapolis, IN

Sponsored by: Society of Trauma Nurses
3493 Lansdowne Drive, Lexington, KY 40517
STN is a licensed continuing education provider in the State of California Board of Registered Nursing.
Provider No. CEP 11062 Course #040313
This certificate must be retained by the licensee for a period of four years after the completion of the course.

Community Hospital North

Indianapolis, Indiana

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

SECTION 3

Indiana Trauma Registry Submissions

"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 an Incident Log of records submitted to the State Registry from the calendar year 2014, January through April. The report was generated using ImageTrend.

IMAGETREND
Making the Web work.

Incident Log

Incident Number	Injury Date	Incident Created On	Incident Created By
		4/18/14 1:53 PM	Julie Packard
[redacted]		5/15/14 10:53 AM	Julie Packard
	1/7/14	4/16/14 3:39 PM	Julie Packard
	1/8/14	4/16/14 2:23 PM	Julie Packard
	1/12/14	4/18/14 2:06 PM	Julie Packard
	1/13/14	4/15/14 5:01 PM	Julie Packard
[redacted]	1/15/14	4/21/14 2:18 PM	Julie Packard
	1/17/14	4/15/14 4:40 PM	Julie Packard
[redacted]	1/20/14	4/21/14 12:10 PM	Julie Packard
	1/23/14	4/16/14 3:06 PM	Julie Packard
	1/26/14	4/15/14 1:50 PM	Julie Packard
	1/26/14	4/15/14 2:24 PM	Julie Packard
	1/28/14	4/18/14 1:36 PM	Julie Packard
	1/30/14	4/18/14 11:32 AM	Julie Packard
[redacted]	1/30/14	4/21/14 2:46 PM	Julie Packard
[redacted]	1/31/14	4/21/14 2:28 PM	Julie Packard
[redacted]	2/1/14	5/19/14 12:35 PM	Julie Packard
[redacted]	2/2/14	5/6/14 1:41 PM	Julie Packard
[redacted]	2/3/14	4/30/14 1:45 PM	Julie Packard
[redacted]	2/4/14	5/29/14 4:38 PM	Julie Packard
[redacted]	2/5/14	5/6/14 1:28 PM	Julie Packard
[redacted]	2/7/14	5/29/14 11:13 AM	Julie Packard
[redacted]	2/14/14	5/19/14 10:44 AM	Julie Packard
[redacted]	2/15/14	5/6/14 1:01 PM	Julie Packard
[redacted]	2/15/14	4/30/14 1:13 PM	Julie Packard
[redacted]	2/17/14	5/29/14 11:01 AM	Julie Packard
[redacted]	2/19/14	5/16/14 2:45 PM	Julie Packard
[redacted]	2/19/14	5/29/14 10:43 AM	Julie Packard
[redacted]	2/20/14	4/30/14 2:17 PM	Julie Packard
[redacted]	2/21/14	5/15/14 10:27 AM	Julie Packard
[redacted]	2/21/14	5/29/14 4:05 PM	Julie Packard
[redacted]	2/23/14	5/19/14 1:21 PM	Julie Packard
[redacted]	2/24/14	4/30/14 2:02 PM	Julie Packard
[redacted]	2/27/14	5/29/14 4:22 PM	Julie Packard
[redacted]	2/27/14	5/29/14 11:27 AM	Julie Packard
[redacted]	2/27/14	5/19/14 10:15 AM	Julie Packard
[redacted]	3/1/14	6/3/14 12:08 PM	Julie Packard
[redacted]	3/2/14	5/30/14 10:16 AM	Julie Packard
[redacted]	3/4/14	5/30/14 11:26 AM	Julie Packard
[redacted]	3/8/14	5/30/14 2:21 PM	Julie Packard
[redacted]	3/8/14	5/30/14 2:30 PM	Julie Packard
[redacted]	3/8/14	6/2/14 1:04 PM	Julie Packard
[redacted]	3/8/14	6/3/14 11:21 AM	Julie Packard
[redacted]	3/10/14	6/3/14 10:35 AM	Julie Packard
[redacted]	3/10/14	6/3/14 10:45 AM	Julie Packard
[redacted]	3/12/14	6/3/14 10:57 AM	Julie Packard
[redacted]	3/12/14	6/2/14 1:13 PM	Julie Packard
[redacted]	3/13/14	6/2/14 12:11 PM	Julie Packard
[redacted]	3/14/14	6/3/14 11:39 AM	Julie Packard

Incident Log

Incident Number	Injury Date	Incident Created On	Incident Created By
[redacted]	3/17/14	5/29/14 4:57 PM	Julie Packard
[redacted]	3/18/14	5/30/14 10:35 AM	Julie Packard
[redacted]	3/20/14	6/2/14 12:27 PM	Julie Packard
[redacted]	3/21/14	6/2/14 1:55 PM	Julie Packard
[redacted]	3/22/14	6/2/14 12:49 PM	Julie Packard
[redacted]	3/23/14	5/30/14 2:47 PM	Julie Packard
[redacted]	3/24/14	6/2/14 1:33 PM	Julie Packard
[redacted]	3/28/14	6/3/14 11:08 AM	Julie Packard
[redacted]	3/28/14	6/3/14 11:54 AM	Julie Packard
[redacted]	4/6/14	6/3/14 1:48 PM	Julie Packard
[redacted]	4/9/14	6/5/14 10:16 AM	Julie Packard
[redacted]	4/11/14	6/5/14 10:26 AM	Julie Packard
[redacted]	4/15/14	6/5/14 10:52 AM	Julie Packard
[redacted]	4/16/14	6/5/14 11:03 AM	Julie Packard
[redacted]	4/17/14	6/5/14 10:41 AM	Julie Packard
[redacted]	4/19/14	6/5/14 11:15 AM	Julie Packard
[redacted]	4/26/14	6/11/14 9:35 AM	Julie Packard
[redacted]	4/30/14	6/3/14 2:09 PM	Julie Packard

Report Criteria

Facility Name: Is Equal To Community NORTH Health Network Comm Hosp

Incident Created On: Is Within last_60_days

Community Hospital North

Indianapolis, Indiana

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

SECTION 4

Trauma Registrar

"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 North Trauma Registrar is Julie Packard. The role summary for this position is attached. Julie has completed the Statewide Trauma Education Session and is registered for the ATS Trauma Registrar Distance Learning Course.

HR USE ONLY

Position Code: 005061
Employee Type: Hourly
Effective Date: February 2014
Developed By: J Hall
HR Consultant: S Pearcy

TITLE: Trauma Registrar

DEPARTMENT AND COST CENTER: 67803CHN

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 ISDOH and JCAHO.

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: High school diploma or equivalent – example GED **(required);**
Prefer one or more of the following certifications : Certified Emergency Medical Technician; Emergency Department Technician or licensed Paramedic; Certified Coding Specialist; Registered Health Information Technician; Registered Health Information Administrator, or Registered Record Administrator.

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

PREREQUISITE 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. Identify what skills are necessary to do this job; e.g., typing
- Maintain at least 4 hours of registry-specific continuing education per year.WPM

SKILLS TESTING: None

REPORTS TO: Trauma Program Manager

SUPERVISES: None

ESSENTIAL FUNCTIONS:

The following functions describe the essential duties of this role. Individuals in this role may not perform all of these duties, or may perform additional, related duties not listed here.

Administration:

1. • Collects and enters data into the trauma registry regarding trauma patients at the Trauma Center in a timely manner.
2. • Collaborates with Information Technology computer hardware and software maintenance and backup to assure proper registry function.
3. • Assigns and scores all injuries utilizing the AIS and ICD-9/10 scoring system. Completes and verifies for accuracy all data collected.
4. • 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.
5. • Ensures compliance with National Trauma Data Bank (NTDB) and Indiana Department of Public Health (ISDH) required standards.
6. • Creates reports and spreadsheets as required and exports or imports data into reports.
7. • 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.
8. • Evaluates current trends in injury mechanism and advises administrative team regarding needs for Prevention Initiatives.
9. • Cognitively reviews data and advises on needs for change in the Trauma Center Plan.
10. • Compiles and analyzes administrative reports for regulatory agencies, participating institutions, and committees as directed by the Trauma Medical Director or Trauma

Program Manager.

11. • Works with the Trauma Program Manager collaborating as an advisor for development of the hospital multidisciplinary team.
12. Research:
13. • Actively participates in educational and clinical research projects conducted by the Trauma Medical Director.
14. • Analyzes data and conducts research relating to education, prevention, and/or trauma services.
15. Service/Teaching:
16. • Prepares data and trends for presentation at national, state, and local meetings.
17. • 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.
18. • Represents the trauma center at national, state, and local meetings, as requested by the Trauma Medical Director.
19. • Serves on local, state, and national committees as requested by the Trauma Program Manager.
20. • Works collaboratively with physicians, coworkers, management and other departments.
21. • 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.
22. Identify those physical, mental, and environmental aspects that are essential to perform the job, and not those aspects that are secondary, or non-essential functions of the position.

PHYSICAL/ENVIRONMENTAL REQUIREMENTS: Please see check list

WORK-PLACE ACTIVITIES*

* Frequencies based on DOT (Dictionary of Occupational Titles) standard frequencies

Activity		Never 0% of the day 0 per day 0		Occasional 1-33% of day 1-66 per day 1 per 15 min.		Frequent 34-66% of day 67-200 per day 1 per 5 min.		Constant 67-100% of day 200 plus per day 1 per 30 sec.
Standing				x				
Sitting						x		
Walking				x				
Bending				x				
Forward				x				
Sideways				x				
Climbing				x				
Grasping				x				
Pushing (Carts, wheelchairs, etc)		x						
Pulling (Carts, wheelchairs, etc)		x						
Twisting at waist				x				
Work above shoulders				x				
Repetitive arm movement						x		
Reaching				x				
Overhead:				x				
Forward:				x				
Side:				x				
Rear:				x				
Squatting				x				
Kneeling				x				
Crawling				x				
Wrist & Forearm						x		
Pronation / Supination						x		
Nondependent patient transfers		x						
Dependent patient transfers		x						
May drive between worksites		x						

Lifting and Carrying		Never		Occasional		Frequent		Constant
Under 10 lbs				x				
10-20 lbs				x				
20-30 lbs				x				
30-40 lbs		x						

Certificate of Completion

Julie Packard

Continuing Education Units (0.5 hours)

Statewide Trauma Education Session

April 2, 2014

SEAL OF THE STATE OF INDIANA 1816

William C. VanGeest II MD

Indiana State
Department of Health

Community Hospital North

Indianapolis, Indiana

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

SECTION 5

Tiered Trauma Activation System

"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

Section 5 includes Community North's Tiered Activation System for Trauma. The TPOPP (Trauma Program Operational Process Performance Committee) is in place to continuously evaluate effectiveness and compliance of this tiered system.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

Emergency Department Tiered Activation Guideline

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 transport 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 Representative, 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:

1. Team Members
   a. Availability of personnel will depend upon level of staffing and may require initiation of on call systems.
      1. Emergency Department (ED) Physicians
      2. Trauma Surgeon
      3. Emergency Department (ED) Nurse(s)
      4. Emergency Department (ED) Charge Nurse
      5. Administrative Representative
      6. Emergency Department (ED) Tech(s)
      7. Respiratory Therapist
      8. Radiology/CT Technologist
      9. Registration/Patient Access

   b. Additional Department Notifications
      1. ICU (as needed)
      2. Operating Room Staff and Anesthesiologist (as needed)
      3. Laboratory/Blood bank
      4. Chaplain (as needed)
      5. Security
2. Levels of Trauma
   a. Code Trauma: (paged out to team):
      1. Systolic B/P <90 mm Hg
      2. Glasgow Coma Scale (GCS) < or =13
      3. Respiratory rate <10 or >29
      4. Patients receiving blood to maintain vital signs

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5. Airway or respiratory compromise as defined by:
    1. BVM, intubation, adjunct airway or cricothyroidotomy in the field
    2. Needle chest decompression
6. Penetrating injury to head, neck, chest, abdomen, back, buttocks, or extremities proximal to the knees and elbows
7. Traumatic amputation proximal to the wrist or ankle
8. Burns >15% or high voltage (>1000volts) electrical injury
9. Any crushed, de-gloved, mangled, or pulseless extremity
10. Pelvic fracture
11. Two or more long bone fractures
12. Flail chest
13. Extremity paralysis suggestive of spinal cord injury
14. Open or depressed skull fracture
15. Victim of hanging who meet above criteria
16. Licensed healthcare provider discretion

b. Trauma alert (not paged out to team):

1. Ejection from vehicle
2. Vehicle roll-over
3. Death in same vehicle
4. Prolonged extrication from vehicle
5. Pedestrian struck by vehicle
6. Falls >20 feet (adults) or >3X the child's height
7. Licensed Healthcare provider discretion

3. Levels of Response
    a. Code Trauma
        1. Upon notification from the ED physician or ED RN, the ED staff will notify the switchboard operator by telephone to initiate the Code Trauma page. The switchboard operator will initiate an alpha-numeric page to the trauma team members defined above.
        2. ED staff will record times team members were paged, time trauma surgeon responded to call, and time trauma surgeon arrived to hospital.
        3. All trauma team members report to the Emergency Department upon paging. The trauma surgeon will initially respond via phone.
    b. Trauma Alert
        1. Upon notification from the ED physician or ED Nurse, the ED staff will notify the Administrative Representative, the Respiratory Therapist and the Radiology/CT Technologist by telephone or other appropriate in-house communication.

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2. There will be no alpha-numeric paging 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.

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Code Trauma Role Definition Summary Guideline

Purpose: To clearly define the roles of individuals involved in the care of trauma patients.

1. Code Trauma 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. Assumes 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 Code Trauma patient and is available in the Emergency Department within 30 minutes of the patient's arrival.
        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 Nurse
        1. Performs primary and secondary assessment of trauma patient upon arrival to Emergency Department, 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. Completion of all transfer records when applicable.
            b. Observation

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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 Emergency Department physician and/or trauma surgeon.

d. Emergency Department Charge Nurse
1. Assigns trauma staff as required.
2. Takes pre-hospital report when Emergency Department 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 Emergency Department 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 Emergency Department.
2. Performs tasks delegated by ED Trauma Nurse (i.e.: 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 Code Trauma 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.

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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 Emergency Department 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 Emergency Department with blood when specifically called.
   2. Collects necessary blood specimens and properly bands patient
   3. Notifies Emergency Department when type-specific and cross-matched blood is available.

j. Registration
   1. Makes chart and places Identification (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 Code Trauma form, and tracks communication times with physicians.
   2. Performs initial notifications as described in 3a and 3b above.
   3. Coordinates phone calls for consultants, inter-facility transfers and transportation as directed.

l. Chaplain
   1. Minister to patient and family members as necessary.
   2. Notify family members as necessary.
   3. Keep family updated on patient care.

m. Security
   1. Crowd control as necessary.
   2. Secures perimeter of Emergency Department and hospital for any potential dangerous activity.

n. Additional Department Notifications
   1. ICU as needed.
   2. Operating Room Staff and Anesthesiologist as needed.

Community Hospital North

Indianapolis, Indiana

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

SECTION 6

Trauma Surgeon Response Times

"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 for section 6 are met with a letter of commitment from the Community Hospital North Trauma Medical Director. The commitment letter affirms intent of the CHN Trauma Surgeons to comply with the standards set forth by the American College of Surgeons. Also included is a letter from Elisa Stott, the Emergency Management Coordinator of CHN, confirming Dr. Pavlik's membership.

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June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this letter is to inform the committee that I serve in the role of Trauma Medical Director. I am pleased to support Community Hospital North in the effort to complete the "in the process Level III Trauma Center requirements. We are committed to working together to provide 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 commited 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 regards to the ATLS certification requirement of the Medical Director I am scheduled to attend a course July 8th & 9th in Minneapolis, MN.

Respectfully,

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community
Hospital North

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eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The purpose of this letter is to inform the committee that Dr Pavlik, our medical director, is a member of Community North's Emergency Management Committee.

Respectfully,

Elisa Stott; CHEP

Elisa Stott
Emergency MGMT/HAZMAT Coordinator

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Emergency Room On Call Schedule
General Surgery Clinical Service
July 2014

		MD On Call	Notes Column
Tuesday	1.	Terrence Ihnat	
Wednesday	2.	Nas Haddad	
Thursday	3.	**John Ditslear **North** Kevin McAree **East**	
Friday	4.	Vincent Delumpa	**New Rotation as of 8/16/2013**
Saturday	5.	Nas Haddad	Bahjat Chabenne
Sunday	6.	Ronald Baughman	Joseph Pavlik
Monday	7.	Scott Mimms	Terrence Ihnat
Tuesday	8.	Bahjat Chabenne	Jon Jansen
Wednesday	9.	Joseph Pavlik	**John Ditslear **North** Kevin McAree **East**
Thursday	10.	Terrence Ihnat	Vincent Delumpa
Friday	11.	Jon Jansen	Nas Haddad
Saturday	12.	**John Ditslear **North** Kevin McAree **East**	Ronald Baughman
Sunday	13.	Vincent Delumpa	Scott Mimms
Monday	14.	Nas Haddad	
Tuesday	15.	Ronald Baughman	
Wednesday	16.	Scott Mimms	
Thursday	17.	Bahjat Chabenne	
Friday	18.	Joseph Pavlik	
Saturday	19.	Terrence Ihnat	
Sunday	20.	Jon Jansen	
Monday	21.	**John Ditslear **North** Kevin McAree **East**	
Tuesday	22.	Vincent Delumpa	
Wednesday	23.	Nas Haddad	
Thursday	24.	Ronald Baughman	
Friday	25.	Scott Mimms	
Saturday	26.	Bahjat Chabenne	
Sunday	27.	Joseph Pavlik	
Monday	28.	Terrence Ihnat	
Tuesday	29.	Nas Haddad	
Wednesday	30.	**John Ditslear **North** Kevin McAree **East**	
Thursday	31.	Vincent Delumpa	

On Call day begins at 7:00 am and ends the following day at 7:00 am. **If you are on call on a day/week/weekend not compatible to your schedule, it is your responsibility to find coverage for your scheduled time.** Please notify Tory Reynolds in Medical Staff Office at (317) 355-5877 or tlreynolds@ecommunity.com, of any changes to this schedule. Thank you

Community Hospital North

Indianapolis, Indiana

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

SECTION 7

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

Included in Section 7 is a signed letter from Dr. Kevin Trappe, the Medical Director for the CHN Emergency Department. The letter confirms that all ED Physicians are board certified and meet credentialing requirements. A copy of the monthly call schedule is also included to show twenty four hour physician coverage.

MEDICAL ASSOCIATES LLP

1500 North Ritter Avenue
Indianapolis, Indiana 46219
317-355-5041

June 5, 2014

Re: Community Hospital East Emergency Department and Community Hospital North Emergency Department

To Whom It May Concern:

Medical Associates, LLP, provides physician coverage to the Emergency Departments of Community Hospitals East and North. Medical Associates currently has twenty seven (27) physicians providing care to all the patients presenting to the emergency departments of Community Hospitals East and North, twenty-four (24) hours a day, every day of the year. All of the physicians of Medical Associates, LLP, are residency trained and board certified and met and/or exceed all credentialing requirements put forth by Community Hospitals East and North.

I am the chairman of Medical Associates, LLP, and the Medical Director for the Emergency Departments of Community Hospitals East and North. As chairman, I ensure that the standards of quality and efficiency are maintained by all the physicians of Medical Associates, LLP.

Kevin Trappe, MD, FACEP

JOSUA J. ARMBRUSTER, D.O.
REY L. BRUNETT, M.D.
CHRISTIAN H. BURKE, M.D.
DAVID K. CHENG, M.D.
RONALD J. EICH, M.D.
JOSEPH F. EZERNACK, M.D.
BLAINE W. FARLEY, M.D.
JEREMY L. GAGAN, M.D.
TRAVIS W. GIEDD, M.D.
MORRIS R. GIESELMAN, M.D.
JAMES A. HARRIS, M.D.
JASON C. HOLLINGSWORTH, M.D.
STEPHEN R. JOHANTGEN, M.D.
SARAM KOERWITZ, M.D.
ROBERT J. McALLISTER, M.D.
JOHN P. McGOFF, M.D.
WILLIAM G. McTURNAN, M.D.
WILLIAM C. MILLER, M.D.
VISHAL Y. PARIKH, M.D.
RICHARD R. ROGERS, M.D.
CHRISTIAN T. ROSS, M.D.
ALBERT L. SOLOMITO, M.D.
KEVIN L. TRAPPE, M.D.
ERIC A. VONDEROHE, M.D.
PAULA E. WILHAM, M.D.

ER MD SCHED

JUNE 2014

SUN	MON	TUE	WED	THU	FRI	SAT
1 RD McGoff ND Ross RE Armbruster NE Gieselman RS2 Hollingsworth NS1 Gagan RS1 Eshelman NS2 Parikh NN Rogers RN House HD McTurnan HN Giedd MINI McAllister	**2** RD Hale ND McGoff RE Ross NE Armbruster RS2 Fossum NS1 Gagan RS1 Cheng NS2 Eshelman NN Parikh RN Rogers HD Koerwitz HN Gieselman MINI Ross	**3** RD McAllister ND Hale RE McGoff NE Ross RS2 Gagan NS1 CB/JB RS1 Koerwitz NS2 Cheng NN Eshelman RN Parikh HD Farley HN Armbruster MINI Fossum	**4** RD Trappe ND McAllister RE Hale NE McGoff RS2 Gagan NS1 Eich RS1 Farley NS2 Koerwitz NN Cheng RN Eshelman HD Vonderohe HN Ross MINI Giedd	**5** RD Fossum ND Giedd RE McAllister NE Hale RS2 CB/JB NS1 Vonderohe RS1 Eich NS2 Farley NN Koerwitz RN Cheng HD Trappe HN McGoff MINI Wilham	**6** RD Giedd ND Fossum RE Trappe NE McAllister RS2 Hale NS1 House RS1 Vonderohe NS2 Eich NN Farley RN Koerwitz HD Miller HN Gagan MINI Farley	**7** RD House ND Giedd RE Fossum NE Trappe RS2 McAllister NS1 CB/JB RS1 Miller NS2 Vonderohe NN Eich RN Farley HD Harris HN McGoff MINI Vonderohe
8 RD Rogers ND House RE Giedd NE Fossum RS2 Trappe NS1 Gieselman RS1 Harris NS2 Miller NN Vonderohe RN Eich HD Wilham HN McAllister MINI Johantgen	**9** RD Parikh ND Rogers RE House NE Giedd RS2 Fossum NS1 Johantgen RS1 Gieselman NS2 Harris NN Miller RN Vonderohe HD Gagan HN Eich MINI Fossum	**10** RD Eshelman ND Parikh RE Rogers NE House RS2 Giedd NS1 Gagan RS1 Johantgen NS2 Gieselman NN Harris RN Miller HD Trappe HN Eich MINI Hollingsworth	**11** RD Cheng ND Eshelman RE Parikh NE Rogers RS2 House NS1 Ross RS1 Gagan NS2 Johantgen NN Gieselman RN Harris HD Hollingsworth HN Brunett MINI McAllister	**12** RD Koerwitz ND Cheng RE Eshelman NE Parikh RS2 House NS1 Ross RS1 Hollingsworth NS2 Gagan NN Johantgen RN Gieselman HD Hale HN Rogers MINI Giedd	**13** RD Farley ND Koerwitz RE Cheng NE Eshelman RS2 Giedd NS1 Ross RS1 Hale NS2 Hollingsworth NN Gagan RN Johantgen HD Armbruster HN Parikh MINI Trappe	**14** RD Eich ND Farley RE Koerwitz NE Cheng RS2 Ross NS1 CB/JB RS1 Armbruster NS2 Hale NN Hollingsworth RN Gagan HD Trappe HN Eshelman MINI Ross
15 RD Vonderohe ND Eich RE Farley NE Koerwitz RS2 Cheng NS1 McTurnan RS1 Trappe NS2 Armbruster NN Hale RN Hollingsworth HD McAllister HN Ross MINI Johantgen	**16** RD Miller ND Vonderohe RE Eich NE Farley RS2 Koerwitz NS1 Giedd RS1 McTurnan NS2 Trappe NN Armbruster RN Hale HD CB/JB HN Hollingsworth MINI Farley	**17** RD Harris ND Miller RE Vonderohe NE Eich RS2 Farley NS1 CB/JB RS1 Giedd NS2 McTurnan NN Trappe RN Armbruster HD McAllister HN Cheng MINI Gieselman	**18** RD Gieselman ND Harris RE Miller NE Vonderohe RS2 CB/JB NS1 Rogers RS1 McAllister NS2 Giedd NN McTurnan RN Trappe HD Johantgen HN Eich MINI Brunett	**19** RD Johantgen ND Gieselman RE Harris NE Miller RS2 Ross NS1 Fossum RS1 Rogers NS2 McAllister NN Giedd RN McTurnan HD Parikh HN Vonderohe MINI Gagan	**20** RD Gagan ND Johantgen RE Gieselman NE Harris RS2 Ross NS1 Fossum RS1 Parikh NS2 Rogers NN McAllister RN Giedd HD Cheng HN Miller MINI Rogers	**21** RD Hollingsworth ND Gagan RE Johantgen NE Gieselman RS2 Harris NS1 Cheng RS1 Fossum NS2 Parikh NN Rogers RN McAllister HD Trappe HN Vonderohe MINI Armbruster
22 RD Hale ND Hollingsworth RE Gagan NE Johantgen RS2 CB/JB NS1 House RS1 Cheng NS2 Fossum NN Parikh RN Rogers HD Ross HN Gieselman MINI Cheng	**23** RD Armbruster ND Hale RE Hollingsworth NE Gagan RS2 Giedd NS1 Ross RS1 House NS2 Cheng NN Fossum RN Parikh HD Farley HN Johantgen MINI Brunett	**24** RD Trappe ND Armbruster RE Hale NE Hollingsworth RS2 CB/JB NS1 Ross RS1 Farley NS2 House NN Cheng RN Fossum HD Eshelman HN Gagan MINI Gagan	**25** RD McTurnan ND Trappe RE Armbruster NE Hale RS2 Ross NS1 Vonderohe RS1 Eshelman NS2 Farley NN House RN Cheng HD Rogers HN Hollingsworth MINI Ross	**26** RD Giedd ND McTurnan RE Trappe NE Armbruster RS2 Fossum NS1 Koerwitz RS1 Vonderohe NS2 Eshelman NN Farley RN House HD McAllister HN Hale MINI Farley	**27** RD McAllister ND Giedd RE McTurnan NE Trappe RS2 Armbruster NS1 Harris RS1 Koerwitz NS2 Vonderohe NN Eshelman RN Farley HD Eich HN Farley MINI Rogers	**28** RD Rogers ND McAllister RE Giedd NE McTurnan RS2 Trappe NS1 Eich RS1 Harris NS2 Koerwitz NN Vonderohe RN Eshelman HD Ross HN Miller MINI Johantgen
29 RD Parikh ND Rogers RE McAllister NE Giedd RS2 House NS1 Johantgen RS1 Eich NS2 Harris NN Koerwitz RN Vonderohe HD CB/JB HN McTurnan MINI	**30** RD Fossum ND Parikh RE Rogers NE McAllister RS2 Giedd NS1 Miller RS1 CB/JB NS2 Eich NN Harris RN Koerwitz HD Johantgen HN Farley MINI Hollingsworth	Cheng Hollingsworth				

COMMUNITY HEALTH NETWORK NORTH, EAST, AND CHVH

MEDICAL ASSOCIATE SCHEDULE KEY

2014

INITIALS	SHIFT	HOURS
RD	Ritter days – East	0700-1500
ND	North days	0700-1500
RE	Ritter evenings – East	1500-2300
NE	North evenings	1500-2300
RS2	Ritter Swing 2nd	1730-0200
NS1	North Swing 1st	0900-1730
RS1	Ritter Swing 1st	0900-1730
NS2	North Swing 2	1730-0200
NN	North Nights	2300-0700
RN	Ritter Nights	2300-0700
HD	Heart Day (CHVH)	0700-1900
HN	Heart Night (CHVH)	1900-0700
MINI	Mini shift Ritter (East)	0500-0900

Community Hospital North

Indianapolis, Indiana

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

SECTION 8

Orthopedic Surgery

"Orthopedic Surgery: There must be an orthopedic surgeon on call and promptly available twenty four 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

Section 8 is met with a signed letter of commitment from the Community North Orthopedic Liaison, Gregory Estes, M.D. The letter confirms prompt availability of orthopedic surgery services and an on-call orthopedic surgeon twenty four hours per day.

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June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 the orthopedic surgery liaison to the Trauma Performance Improvement and Patient Safety (PIPS) Committee. I am pleased to support Community Hospital North in the 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 an orthopedic surgeon on call and promptly available to the Community North ED 24 hours per day.

Respectfully,

Gregory Estes, M.D.
Orthopedic Surgery Section Rep

Joseph Pavlik, M.D., FACS
~~Trauma Medical Director~~

updated #5

THE INDIANA ORTHOPAEDIC CENTER

		NAME	PAGER	PRIVATE
		Eric S. Leaming, M.D.	[redacted]	Regina and Amy
		Richard W. Eaton, M.D.	[redacted]	Dina
		Douglas A. Kuhn, M.D.	[redacted]	Dottle
		Edward P. Todderud, M.D.	[redacted]	Susan
		Ralph H. Kahn, M.D.	[redacted]	Barb
		Jon M. Sieber, M.D.	[redacted]	Shonda
		Herbert M. Biel, M.D.	[redacted]	Brandi
		C. Melton Doxey, M.D.	[redacted]	Mitzi
		Brett R. Fink, M.D.	[redacted]	Johanna
		Gregory L. Estes, M.D.	[redacted]	Leslie
		Philip C. Saller, M.D.	[redacted]	Anna

UPDATED 10/2011

COMMUNITY NORTH ORTHOPEDIC CALL SCHEDULE

57

June 2014

VSW 6/14

June 2014

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July 4

Su	Mo	Tu	W	Th	Fr	Sa
		1		3	4	5
6	7	8		10	11	12
13	14	15		17	18	19
20	21	22		24	25	26
27	28	29		31		

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday		Saturday
Jun 1 - 7	Jun 1 EPT ESL OUT ~~GWF (O)(ER)~~ PCS	2 EPT CMD ESL OUT GWF RWE ~~TRANCIK (ER)~~	3 EPT CMD ESL OUT JMS ~~MLS (ER)~~ RHK	4 BRF EPT CMD ESL OUT ~~GEE (ER)~~	5 EPT CMD ESL OUT ~~GWF (ER)~~ NO GF COVERAGE RWE	6 EPT CMD ESL OUT ~~JMS (ER)~~ RHK	7	PT CMD ESL OUT ~~JMS (ER)~~ IO GF COVERAGE RHK
Jun 8 - 14	8 EPT CMD ESL OUT JMS NO GF COVERAGE ~~RHK (ER)~~	9 EPT OUT ESL RWE ~~VNE (ER)~~	10 CMD EPT OUT HMB ~~JMK (ER)~~ NO GF COVERAGE	11 ~~BRF (ER)~~ GLE	12 ~~BRF (ER)~~ EPT	13 ~~BRF (ER)~~ GWF	14	BRF ~~GWF (ER)~~
Jun 15 - 21	15 ~~BRF (ER)~~ GWF	16 HMB RWE ~~SBS (ER)~~	17 ESL ~~PCS (ER)~~	18 ~~CMD (ER)~~ GWF	19 CMD EPT NO GF COVERAGE ~~TRANCIK (ER)~~	20 BRF OUT CMD HMB ~~JMK (ER)~~ NO GF COVERAGE	21	BRF OUT ~~CMD (ER)~~ HMB
Jun 22 - 28	22 BRF OUT CMD HMB NO GF COVERAGE ~~VNE (ER)~~	23 BRF OUT GLE NO GF COVERAGE RWE ~~TRANCIK (ER)~~	24 BRF OUT EPT ~~MLS (ER)~~ NO GF COVERAGE PCS	25 BRF OUT ~~JMS (ER)~~ RHK	26 BRF OUT HMB NO GF COVERAGE RWE ~~TRANCIK (ER)~~	27 BRF GLE OUT ESL ~~PCS (ER)~~	28	BRF GLE OUT ESL ~~PCS (ER)~~
Jun 29 - Jul 5	29 BRF GLE OUT ESL PCS ~~VNE (ER)~~	30 BRF GLE OUT CMD ~~EPT (ER)~~ NO GF COVERAGE	Jul 1	2	3	4	5	

Watts, Stacia

/2014 8:14 AM

Community Hospital North

Indianapolis, Indiana

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

SECTION 9

Neurosurgery

"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."

NARRATIVE RESPONSE AND DISCUSSION

Section 9 contains a commitment letter signed by the Neurosurgery Representative for Community Hospital North. 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, and with IU Health/Riley for pediatric neurosurgery patients who require care at a Level I facility. There is a call schedule included in this section as well to verify that neurosurgical services provide twenty four hour per day coverage. The PIPS program will continuously evaluate all cases to demonstrate care appropriate to ACS standards.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 the Chief of Neurosurgery for Community Hospital North. I am pleased to support Community Hospital North in the 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.

The Community North Department of Neurosurgery is committed to providing care for patients with traumatic injury. I further understand that we have transfer agreements in place to accept Trauma patient transfers determined to be beyond our scope by our Neurosurgery Plan for Trauma Patients.

Respectfully,

John T. Cummings Jr, M.D.
Chief of Neurosurgery

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 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.

- 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

Respectfully,

John T. Cummings Jr, M.D.
Chief of Neurosurgery

Joseph Pavlik, M.D.
Trauma Medical Director

CHE / CHN/CHS NEUROSURGEON ON CALL 4pm-7 am

8W 5/30

June 2014

Please call the office a[redacted] during regular office hours

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					30 Cummings	31 Cummings 24 Hour Covera
1 Cummings 24 Hour Coverage	2 Donaldson	3 Rendel	4 Sloan	5 Cummings	6 Kim	7 Kim 24 Hour Covera
8 Kim 24 Hour Coverage	9 Hall	10 Sloan	11 Cummings	12 Rendel	13 Sloan	14 Sloan 24 Hour Covera
15 Sloan 24 Hour Coverage	16 Hall	17 Cummings	18 Kim	19 Hall	20 Rendel	21 Rendel 24 Hour Covera
22 Rendel 24 Hour Coverage	23 Donaldson	24 Cummings	25 Sloan	26 Kim	27 Donaldson	28 Donaldson 24 Hour Coverag
29 Donaldson	30 Sloan					

Dr. Cummings - Pager[redacted]
Dr. Sloan - Pager[redacted]
Dr. Donaldson - Pager[redacted]
Dr Hall - Pager[redacted]
Dr. Rendel - Pager[redacted]
Dr. Kim - Pager[redacted]

**Weekend and Holiday Call is 24 Hour Coverage

NIGHT CALL

Community Hospital North

Indianapolis, Indiana

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

SECTION 10

Transfer Agreements and Criteria

"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

Section 10 requirements are met with a copy of the Trauma Transfer Guideline document and copies of Transfer Agreements with Level I facilities Eskenazi Health, IU Health, and IU Health/Riley.

COMMUNITY PHYSICIAN NETWORK – COMMUNITY PHYSICIANS OF INDIANA
PREPARATION/APPROVAL PROCESS FOR SERVICE CONTRACTS

YPE OF CONTRACT Service Agreement – Transfer Agreement
CONTRACTOR IU Health Hospitals

INITIATION/PREPARATION:

Originator: Ron Lewis
Department: Neurology
Location: 7330 Shadeland Station
Telephone: [redacted]
Responsibility for Drafting:
Outside Party Legal X

A. LEGAL
Reviewed: _____ Approved: _____
By: Template Date: _____

RETURN TO Cathy Leonard AFTER EACH APPROVAL STEP

B. CONTRACT SUMMARY

COST $ N/A Hr./Mo./Yr. Ea.

ERM: June 1 20 14 to
*May 31 20 15

PURPOSE & DETAILS:
Renews annually in successive one-year terms
Transfer agreement between CHNw and IU Health, which includes IU Methodist, Riley and IU University hospitals, to transfer a patient from CHNw to above hospital(s) when medically necessary.

C. Is a Bus. Assoc. Agree. Req. under HIPAA Privacy Rules?
YES Included NO _____

D. FORECASTED
YES _____ NO _____
If no, please explain:
N/A

E. PURCHASING Approved?
YES _____ NO _____
.. no, please explain:

F. OWNER
By: Ron Lewis
See Attached Date: 5/16/2014

J. CPN COO
By: [signature]
Tony Javorka Date: 6/25/14

K. CPN PRESIDENT
By: [signature]
Dr. Ramarao Yeleti Date: 6/24/14

J. CPE Chief Physician Executive
By: [signature]
Dr. Tim Hobbs Date: 6/25/14

K. DISTRIBUTION OF CONTRACT AFTER FULL EXECUTION:
1. Scanned copy saved to G: drive
2. Original mailed via Interoffice to Legal
4. Enter into Contract Tracking Database
5. Email scanned copy to:

Dept.	Person(s)	Date
*CPN Contract Notification		
Copy to Originator		

L. Send One Original Contract to address below:

TRANSFER AGREEMENT
BETWEEN
COMMUNITY HEALTH NETWORK
AND
INDIANA UNIVERSITY HEALTH, INC.

THIS AGREEMENT is entered into, by and between Community Health Network, Inc. an Indiana nonprofit corporation and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "HOSPITAL"), and Indiana University Health, Inc., an Indiana nonprofit corporation (hereinafter "IU Health").

WHEREAS, HOSPITAL is the owner and operator of hospitals commonly referred to as Community Hospital North, Community Hospital East, Community Hospital South, and Community Howard Regional Health;

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	IU Health
Community Health Network 7330 Shadeland Station Indianapolis, IN 46256	Indiana University Health, Inc. 340 West 10th Street, Suite 6100 Indianapolis, IN 46206-1367
Attention: President/CEO General Counsel	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.

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XVIII. 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 1st day of June, 2014.

HOSPITAL:

COMMUNITY HEALTH NETWORK

By: Timothy Hillman

Title: Chief Physician Executive

AND

IU HEALTH:

INDIANA UNIVERSITY HEALTH, INC.

By: Jeffrey Sperring

Jeffrey Sperring, M.D.
President, IU Health Methodist, Riley and University Hospitals

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

Trauma Transfer Guidelines

- The on call Trauma Surgeon or Emergency Department physician will decide which patients are to be transferred to a higher level of care.
- The injuries listed below are strongly recommended by the American College of Surgeons to be transferred to a level I or level II designated center.
  - ✓ Carotid or vertebral arterial injury
  - ✓ Torn thoracic aorta or great vessel
  - ✓ Cardiac rupture
  - ✓ Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
  - ✓ Major abdominal vascular injury
  - ✓ Grade IV or V liver injuries requiring >6 U RBC transfusion in 6 hours
  - ✓ Unstable pelvic fracture requiring > 6 U RBC transfusion in 6 hours
  - ✓ Fracture or dislocation with loss of distal pulses
  - ✓ Penetrating injury or open fracture of the skull
  - ✓ Glassgow Coma Scale < 14 or lateralizing neurologic signs
  - ✓ > 2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
  - ✓ Open long bone fracture
  - ✓ Significant torso injury with advanced comorbid disease
- The on call trauma Surgeon or Emergency Department physician will call **1-800-4-Trauma** for all patients being transferred to Eskenazi and will be connected directly to Eskenazi's on call trauma surgeon.
- For patients being transferred to IU Health the Surgeon or Emergency Department physician will call the IU Health 24/7 Transfer Center a[redacted]
- The Surgeon or Emergency Department physician will decide if the patient travels via ground or aeromedical transportation with the most appropriate level of care (ALS, BLS).
- There will not be any delay in transfer due to laboratory or diagnostic testing that does not have any impact on the resuscitation of the patient.
- The transferring RN will complete the transfer checklist.
- The transferring RN will call report to the receiving facility.
- The transferring RN will complete the transfer form (electronic and paper).
- The transferring RN will accompany the patient when deemed necessary by the Surgeon or Emergency Department physician.

1-800-4TRAUMA Patient Transfer Request Line

1. Answer Trauma Phone by dialing [redacted]
2. **Pickup call stating, "Sidney and Lois Eskenazi Hospital, this is [your first name] would you like to transfer a patient to Eskenazi Hospital?"**
3. Initial time of call:_____AM/PM Date of call:_____ Answered by(initials):_____
4. Is this a ***General Surgeon TRAUMA or Ortho Surgeon TRAUMA*** patient? (circle one)
5. Patient's age: _____ If 14 years old and younger, transfer to Riley at 963-3333.
6. **********MD Notification**********

   A. **GENERAL SURGEON TRAUMA**

   Dr. Gerardo Gomez 1st [redacted]
   2nd [redacted]
   3rd [redacted]
   wait for response, if no response (after hours)

   Dr. Clark Simons (If Dr. Gomez is not available)
   1st [redacted]
   2nd [redacted]
   3rd [redacted]

   B. **ORTHO SURGEON TRAUMA**

   Dr. Brian Mullis 1st [redacted]
   2nd [redacted]

   Dr. Karl Shively (If Dr. Mullis is not available)
   1st [redacted]
   2nd [redacted]

7. Name of Surgeon reached: _____
8. 3-way conference call documentation of Physician to Physician conversation regarding patient:
   A. Hospital / ambulance service name: _____
   B. Physician requesting transfer name: _____
   C. From location: City: _____Transferring Physician's phone number_____
9. Patient's name: _____ Patient's DOB: _____
10. End time of call with Eskenazi Surgeon: _____am/pm Did Surgeon accept transfer? _____
11. Ask the Physician who is requesting the transfer if they would like you to arrange air ambulance transport.
12. Air Ambulance transport requested? __Y / N If yes, please ask weight of patient:_____ lbs.
13. Health Connections to call for Air Ambulance, call : [redacted]
14. Notify the following whenever a transfer is accepted by MD:
    A. Emergency Room Charge RN _____am/pm
    B. Health Connection Charge RN _____am/pm
    C. Burn RN _____am/pm (if applicable)

Please See

Addendum A

Community Hospital North

Indianapolis, Indiana

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

SECTION 11

Trauma OR, Staff, and Equipment

"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."

NARRATIVE RESPONSE AND DISCUSSION

Section 11 includes a letter of commitment from Michael Caldwell, M.D., Anesthesia Section Representative for Community North Hospital, and a copy of anesthesia call schedule demonstrating twenty four hour coverage. Also included are the OR Staffing policies, the OR equipment list, and the Surgical Services Quality/Safety Management Plan.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 North Hospital in the 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,

Michael Caldwell, M.D
Anesthesia Section Rep

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 9/16/10

NPP#: ORSPP: S-05
Page 1 of 1
EFFECTIVE: 6/12/14

TITLE: STAFFING

Performed by: Team Leader or Designee

Purpose: To provide guidelines for staffing in Surgical Services

General Information: None

Policy Statements:

1. A Registered Nurse will be assigned to perform circulating duties in each Operating Room.
2. A Registered Nurse, Surgical Technologist, Certified Surgical Tech, Student Surgical Technologist (SST), CSTFA or a trained Student Extern will be assigned to scrubbing duties as appropriate.
3. The demands of each room schedule will be optimally matched with skills and expertise of assigned staff.
4. Assignment of additional personnel per procedure will be provided, with consideration to:
   a. Acuity/complexity of procedure (eg trauma, total joint replacement).
   b. Physician request (eg scrub assistant).
   c. Special equipment (eg laser).
5. One CHI competency verified laser nurse will be assigned to each laser procedure.
6. Department Coverage
   a. CHE: Department coverage consists of in house RN staffing 0700-2300 Monday-Friday and 0700-1900 on Saturday and Sunday - - with the exception of holiday coverage. CHE Monday – Sunday, 1900 – 0700, weekends and holidays will be covered by a designated on-call team consisting of at least one RN.
   b. CHN: Department coverage consists of in house RN staffing 24 hours a day. Holiday call is covered by a designated on-call team consisting of at least one RN.
   c. CHS: Department coverage consists of in house RN staffing 0700-1830 Monday-Friday. Weekday nights (1830-0700), weekends, and holidays are covered by a designated on-call team consisting of at least one RN.
   d. CHVH: Department coverage consists of in house RN staffing 0630-1700 Monday-Friday. Outside of timeframe is an on-call team.

Equipment: None

Procedure: None

Documentation Guidelines: None

References: None

Approved by:	Perioperative NPP Subcommittee	Date:	5/2014
	Infection Prevention	Date:	5/14/2014
	Risk Management	Date:	5/14/2014
	CHVH	Date:	5/14/2014

Approved:	NPP Steering Committee	Date:	5/14/2014

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

Staffing and On Call Guidelines for CHN Surgery Personnel

Operating Rooms:

CHN Surgical Services is covered with staff (RN and/or CST) 24/7, with the exception being Holidays. Monday thru Friday, the department is staffed to run eight rooms until 3pm, five rooms until 5pm, and 2 rooms until 11pm. After 11p one person is staffed in the department with one person on call until 7am, providing the ability to run one room. Saturday and Sunday the department is staffed to run one room at all times.

Holidays, the OR maintains an On-Call staff consisting of three members (RN and/or CST). These staff members are to deliver care to the patients requiring emergency surgical procedures during the hours not covered by on duty personnel. Staff who are assigned, or who volunteer for this duty, are responsible for upholding the department's high standards of quality patient care and conducting their duties according to the policies and procedures set forth by the hospital and the department.

U/PACU:

The POCU/PACU is staffed M-F 5:00am- 10:30pm. From 6:00pm-6:00am, there will be two RN's in an on-call status to cover the POCU/PACU area, with a required arrival time of 30 minutes from notification. Weekends (Saturday and Sunday) will be staffed with two RN's from 6:00am – 6:30pm. Two RN's will be on-call to cover any activity in the POCU/PACU area from 6:30pm – 6:00am. First call person will cover the hours of 1830-0600; designated Second call person will cover call for a 24 hour period of time. During Phase One recovery, there will always be two RN's in the POCU/PACU area per ASPAN Practice Recommendations.

Procedure:

1. The on call physician will notify the staff of an emergency surgery. If you are called for a procedure scheduled for a specific time, all staff is expected to arrive to the hospital within 30 minutes of notification.
2. If a case cart is needed for the procedure, OR staff should call CSR [redacted] advance so the supplies will be ready when the OR staff arrives.
3. Dress for duty per department policy.
4. In the event that the Surgery phone is forwarded (Holidays and unforeseen circumstances), un-forward surgery phones upon arrival so that calls are received on th[redacted]one.
5. Prepare the OR and PACU for the procedure being done.
6. The patient is brought to the surgery department by either the On Call RN (usually the PACU RN) or the Nursing Unit/ED personnel. Transport and admit the patient per departmental policies.
7. Prepare the department for the next procedure/shift which includes:
   a. washing utilized instrumentation.
   b. Non-disposable items should be returned to their designated storage areas.
   c. Return case cart and supplies to CSR.
   d. Notify Environmental Services that the OR was used and needs cleaning.
   e. Cultures (and other lab specimens—except tissue histology) must be taken to the Laboratory at the completion of the case.
   f. The OR and PACU must be totally re-stocked.

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

Special Conditions/Considerations

1. Requests for F/S should be made by contacting the pathologist on call (schedule on OR cork board).
2. Team Leaders and Coordinators should verify the On Call schedule is accurate and up to date.
3. Both PACU RNs will be called in for all patients scheduled for a general, regional or IV Sedation anesthetic. The PACU RN be called in for patients scheduled for local anesthesia at the discretion of the OR call team with consideration to the patient's medical condition/history and admission status (i.e. OP).
4. At least two RNs will remain in the department while patients are in the department.
5. Potential functions of the PACU RN preoperatively and intraoperatively include, but are not limited to:
   - -Pick up patient preoperatively; obtain required consents and other signatures.
   - -Function as a "runner" i.e. obtains blood; deliver blood samples to lab, point of care testing
   - -Answer telephones
   - -Obtain preoperative information for upcoming cases
   - -Communicate with patient's family
   - -Remain readily accessible while patient is in the intraoperative phase of care
6. Potential functions of the OR staff post operatively:
   - -Assist with direct patient care as needed (i.e. restraining, V/S, assist with positioning)
   - -Remain in PACU I at the PACU RN's discretion
   - -Function as a "runner" i.e. obtains blood, deliver blood samples to lab
   - -Remain readily accessible until patient has been stabilized.

Community Health Network

Effective Date: 2/1/2014

'LE: SCHEDULING GUIDELINES FOR SURGICAL PROCEDURES AT COMMUNITY HOSPITAL NORTH

Purpose: Provision of guidelines for scheduling surgical procedures, both elective and emergency, in order to provide quality safe patient care services, efficient use of physician time and efficient utilization of operating room services staff and facilities.

Policy Statements:

1. The administration of Surgical Services is a cooperative effort between the Surgical Services Leadership and the respective Medical Directors.
2. The Executive Director or designee (Clinical Director, OR Team Leader) is responsible for the provision of nursing and ancillary personnel, as well as appropriate functioning physical facilities.
3. The Medical Director of Surgical Services is responsible for addressing matters involving the physicians utilizing Surgical Services.
4. All surgical cases scheduled will be done in accordance with Infection Control policies.
5. Inpatient surgical procedures on patients 14-16 years of age necessitating admission to the ICU will be done only with mutual consent of an Adult Intensivist, Pediatric Hospitalist, surgeon, anesthesiologist and ICU and Pediatrics Directors.
6. Procedures involving NICU patients will be a collaborative effort among the Neonatal Nurse Practitioner, the Medical Director of the NICU, Pediatric Surgery, Surgical Services Leadership, and the Surgical Services Medical Director.

Definitions

'd On/Urgent Procedure: Surgery cases added to the current or next day's surgery schedule after the official schedule ...s been closed or published. These procedures are not immediately life-threatening but will be expedited and worked into the schedule as soon as possible.

Block Scheduling: A system of reserving specific routine periods of operating room time for individual and/or group practice surgeons based upon a defined pattern of utilization.

Elective Procedures: Surgical cases scheduled in advance into assigned block or open time available for surgeons without assigned block time

Emergent Procedure: A life/limb threatening condition that requires immediate surgical intervention. An emergency will go into the first available room and may require bumping another surgery or rearranging the prescheduled cases. If bumping another case is necessary, it is the surgeon's responsibility to notify the surgeon whose scheduled case will be affected.

First Case On Time Start: Applies to first case in every room with a start time before 9 AM.

Open Time Scheduling: Periods of operating room time unreserved and available for scheduling on a first come first serve basis. Surgeons without block time have priority for scheduling in unreserved time.

Release Time: Automatic release time for unused block time converting to open time.

Scheduled Start Time: The scheduled start time is defined as "the patient in the room time."

Turnover Time: The time the patient leaves the room until the time the next patient enters the room. This includes the clean up and set up time during this time frame.

General Information:

1. Eight (8) general, multipurpose operating rooms are available for scheduling.
2. With the exception of holidays, the OR is staffed 24 hours a day, 7 days a week with additional on-call staff as needed. Holidays are covered by a designated On-Call Team. Recognized holidays include:
    a. New Years Day
    b. Memorial Day
    c. Fourth of July

d. Labor Day
e. Thanksgiving
f. Christmas
g. A reduction in available ORs for scheduling may occur New Years Eve, during Marion and Hamilton County Spring Breaks, the day after Thanksgiving, Christmas Eve and the week between Christmas and New Years.

3. Cases may be scheduled Monday through Friday between 8:00 am to 4:30 pm. Scheduling requests outside of these times will be determined on a case by case basis. Only emergencies and urgent cases will be done after the scheduled OR hours.
4. Surgery schedules are closed/published Monday through Friday at 4:30pm. Any request outside of this time will be treated as an add on.
5. Availability of time on the OR schedule will be determined by:
   a. Type of anesthesia required
   b. Availability of nursing staff
   c. Availability of supplies and equipment (e.g., laser, x-ray).
   d. Length of time needed for procedure, including set-up time, operating time and clean up time.
6. On a holiday requests for scheduling on the next business day will be made by calling surgery at 621-5016 and recording the information on voice mail. You will be notified the next day as to the time of the procedure.

Procedure

1. To schedule a case call the **Scheduling Office** a[redacted]between 7:00 am and 4:30pm. After these hours the scheduling line will be forwarded to the charge nurse to handle requests for add on/urgent or emergent procedures.
2. Scheduling requests may also be submitted via fax a[redacted]See attached fax request form.
3. All requested information must be provided to the surgery scheduler prior to the surgery being placed on the schedule. Information necessary to put a case on the schedule includes, but is not limited to:
   a. Date and time requested
   b. Surgeon's name
   c. Type of anesthesia
   d. Procedure to be performed
   e. Patient's name, phone number, and date of birth, and social security number
   f. Length of time needed
      i. We reserve the right to alter surgeon requested time based on historical case data.
   g. Special supplies or equipment needed
   h. Patient status
      i. Inpatients, AM admissions, and outpatients must have a bed reservation
      ii. Patients cannot be placed on the schedule in an 'observation' status. CMS dictates that an observation status may only be deemed necessary after the procedure has occurred and the patient's status at that time warrants observation.
      iii. *The patient status of a Medicare patient is governed by Medicare's Inpatient Only List. When scheduling Medicare patients as an outpatient, be prepared to share the predicted CPT code. Scheduling personnel will check this CPT code against the Inpatient Only List. If the CPT code is on this list, the patient must be scheduled and treated as an inpatient.*
   i. "Flipping Rooms"
      i. This applies only to the Orthopedic Service when scheduling Total Joint cases
      ii. Must have at least four primary joints scheduled on the date requested
      iii. If one of the four cases is a more complex case (i.e. - bi-laterals and revisions), it must be scheduled as the last case in the series.

4. Cancellation of Cases
   a. If the surgeon or surgeon's office needs to cancel a case, ca[redacted] alert the department.
   b. If the patient fails to report at the pre-determined time, surgery scheduling will notify the surgeon and anesthesia.
   c. Cancellations may be made by the surgeon and/or anesthesia after the patient has arrived if a patient fails to have completed pre-surgery requirements (lab work, consent, registration, etc.).
   d. If there is a cancellation or change in schedule:
      i. Scheduled cases will be offered earlier times first at the discretion of the Medical Director and/or charge nurse or designee,
      ii. Add-on cases will be considered next
5. Add-on Cases
   a. Scheduling add-ons will be on a first come, first serve basis.
   b. Anticipated start times will be identified when the procedure is scheduled.
   c. Surgeons will be notified as soon as possible if the start time may be delayed.
   d. Should a surgeon be unable to move up when requested, that time may be filled with another procedure of similar length.
   e. No substitution of patient names or unrelated procedure will be accepted.
   f. The above referenced patient information will be required at the time of scheduling from the physician or the physician's office. The surgery may not be scheduled with only a patient name.

6. Cases Scheduled After Hours/Holidays/Weekends

   <u>After Hours (after 11pm Monday – Friday) and Holidays</u>
   a. The surgeon will ca[redacted]nd speak with the nurse on duty to schedule the procedure
   b. The anesthesiologist on-call will be contacted with case information, which will include the estimated/requested start time.
   c. The nurse on duty will then alert the "on-call" team of the emergency case, and communicate with the surgeon to verify the start time.

   <u>Weekends</u>
   a. Weekends are reserved for the scheduling of urgent/emergent cases.
   b. Every effort should be made to do cases M – F.
   c. Surgical procedures that are to be performed on a Saturday may be scheduled beginning at 5pm on Friday.
   d. Surgical procedures to be performed on a Sunday may be scheduled anytime 24 hours prior.
   e. Outpatient surgery cannot be performed on the weekend (Saturday or Sunday) unless it is classified as an urgent/emergent type case with the exception of Fertility Services.

<u>Management of the Daily Schedule</u>

1. It is a team effort to start surgery on time and all participants of the OR team (including physicians) will be held accountable to ensure timely starts.
2. Except in emergency situations, patients will not be transferred to the OR until all team members are present and required documentation is complete. Required documentation consists of:
   a. Complete history and physical that has been appropriately updated the day of surgery.
   b. Signed surgery and anesthesia consents
   c. Signature indicating Informed Consent by the physician
   d. Completion of surgical site marking

physician consistently fails to meet requirements, it could result in penalties such as loss of Block Time, inability to schedule, etc.

3. In the event of delays, the operating room staff will proactively notify surgeons by placing calls or paging to communicate as soon as possible. An indication of the estimated length of time before the procedure can begin will be given.
4. The charge nurse and the anesthesiologist in charge shall collaboratively be responsible for adjusting time frames due to cancellations, delays or any unexpected time openings. Elective cases will have priority for completion over add on cases, however, facilitating the completion of the schedule in a timely efficient manner will be taken into consideration.

Block Scheduling Guidelines

1. There is a combination of block and open scheduling time.
    a. A minimum of one OR will be maintained at all times for open scheduling.
2. Block time owners may not allocate their block time to another surgeon.
3. To qualify for block time the requestor must demonstrate consistent utilization of the OR.
4. Block time is released 120 hours (5 business days) prior to scheduled block time if the time is not utilized.
5. To maintain block time, utilization must be at least 75% as measured on a quarterly basis. A calculation of turnover time will be included towards block time utilization.
    a. Block time owners will be made aware of utilization on a quarterly basis. If at the end of a quarter, utilization is below 75%, the owner will have the next quarter to improve utilization to 75%. If 75% is not met, adjustments to decrease the block time will be made.
    b. Prior to adjustments of decreasing time, outside factors will be taken into consideration (i.e: surgeon in front of you consistently runs over into your block time thereby preventing you from reaching 75% utilization)
    c. Utilization above 75% will be evaluated on a quarterly basis to determine if an increase in time is needed.
    d. Time utilized outside of assigned block time will not be allocated toward block time utilization.
    e. Block Utilization % = $\frac{\text{hours used inside the block + allowed turnover time (less approved released time)}}{\text{block hours allocated (less approved released time)}}$
6. If a surgeon has block time that covers the first case of the day, first case on time starts will be monitored and will play a role in maintaining block time.
    a. If a surgeon has three late starts in one quarter related to not being present 30 minutes prior to the start of the first case of the day, the surgeon will have the next quarter to correct his first case on time starts prior to block time being adjusted.
7. Outside of emergency and urgent add-ons, surgeons with block time must schedule and fill this time prior to being allowed to schedule in open time. Surgeons without block time will be given priority in open time.
8. The following equipment will be blocked based upon necessity to do procedure. Block time inclusive of equipment will be released two weeks prior.
    a. daVinci
    b. O-arm
9. It is the responsibility of the block time owner to manage and release block time appropriately to ensure adequate utilization. It is the surgeon's responsibility to notify the OR scheduling office at least two weeks in advance when block time will not be needed related to vacation or time off. Block time releases two weeks prior to the surgery made will not be counted against block time utilization.

ROLE SUMMARY

Note: Statements included in this description are intended to reflect in general the duties and responsibilities of this classification and are not to be interpreted as being all-inclusive.

TITLE:	POCU/PACU Nurse
DEPARTMENT:	Surgical Services
REPORTS TO:	Team Leader POCU/PACU
OTHER INTERNAL CONTACTS:	Center Personnel
EXTERNAL CONTACTS:	Patients and families, General public

JOB SUMMARY:

Responsible for the delivery of patient care that promotes safety and well-being of patients and staff. Provides physical, educational and technical care and support. Demonstrates strong assessment skills both pre and postoperatively. Appropriate assessment includes physical, psychosocial/family, cultural, personal beliefs or restrictions, cognitive abilities, pain and comfort needs. Participates in the development and implementation of policies and procedures. Identifies immediate problems in the pre and postoperative phase and intervenes appropriately. Performs direct patient care preoperatively and postoperatively; Assesses, documents and manages postoperative pain; demonstrates ability to assess airway adequacy and intervene quickly and appropriately when necessary; demonstrates proficiency with cardiac monitoring and interpretation, Demonstrates understanding and knowledge of Phase I and Phase II recovery nursing principles and expectations. Ensures continuity of patient care by communicating with all surgeons, anesthesiologists, OR personnel and other staff any pertinent or abnormal findings. Requires high degree of responsibility, confidentiality and discretion. Remains calm and effective in stressful situations and takes initiative in emergency situations. Able to prioritize, organize and multi-task. Supports the organization mission and vision. Promotes teamwork and functions as a team member providing care that encompasses compassion, collaboration and trust. Possesses a moral obligation to promote the welfare, health and safety of the patient, and to advocate on the patient's behalf whenever necessary.

Job Domains

A. Preoperative Phase

- Patient evaluation should take place sufficiently in advance of the scheduled surgery to integrate an appropriate evaluation, necessary testing and thorough patient education per policy.

B. Phase I and Phase II

Managing Patient Airway

- Assess airway quality and function.
- Connect airway to t-tube oxygen and suction airway as needed.
- Extubate patients with endotracheal and larynx-mask airway.
- Place oral and/or nasal airways as needed.
- Evaluate breath sounds and document.
- Identify signs and/or symptoms of respiratory distress and intervene appropriately
- Administer breathing treatments as needed.
- Properly position head for optimal airway function.
- Use bag-valve-mask, suction equipment, oral and nasal airways, t-tubes, suction catheters, oximeters, mist puffers.

Assessment of Surgical Site

- Assess integrity of surgical site.
- Notify surgeon of increased bleeding, bruising, discoloration, temperature, heat, redness or swelling at site.
- Identify signs and symptoms of infection.
- Identify any drains and record amount of drainage.
- Document type of dressing (4x4s, bandaid, ace wrap, etc.) and site.

D. Direct Patient Care – Preoperative and Postoperative Phase

- Assess pain level and need for pain medications continuously until optimal response is obtained.
- Administer pain and other medications with knowledge of dosage and effects.
- Position patients comfortably and teach breathing techniques and alternatives for pain management.
- Locate oxygen tubing, supplemental oxygen masks, t-tubes, and airway supplies efficiently.
- Sign off doctor orders as received.
- Perform surgeon's orders (ice bags, medications including pain meds and antibiotics, elevation of extremities, etc.).
- Monitor and record IV fluids, incisional drains, empty catheters, etc.
- Obtain temperature and intervene as appropriate with warm blankets or heating or cooling methods.

- Verify and validate patient and family awareness of discharge instructions.
- Ensure that post-operative teaching is understood by patient/family by performance of tasks or repeating instructions verbally.
- Identify discharge criteria.
- Discharge patient according to discharge criteria to a responsible adult.

E. Discharge Planning

- Establish availability of responsible adult to provide home care and transportation home.
- Verify family and patient education regarding pain management and medication, nourishment, activity, safety and follow-up care.
- Provide written discharge instructions

F. Lab Tests

- Obtain labs, referrals blood, X-rays using the correct process.
- Competent and proficient in I-Stat and Accucheck testing.
- Perform urine pregnancy tests according to anesthesia criteria.

G. Venipuncture and Blood Draw

- Identify proper veins or capillaries to use for obtaining blood samples.
- Competent and proficient in venipuncture.
- Reassure and educate patient before procedure.
- Identify correct collection device and/or vacuum tube for test to be performed.
- Obtain blood sample for point of care and I-STAT or Accucheck testing as ordered by physician.
- Obtain I-STAT or Accucheck for diabetic patients.

H. Use of Monitoring Equipment

- Attach leads and monitoring equipment correctly to patient to monitor patient's vital signs and EKG .
- Read and interpret values (EKG, B/P, heart rate, pulse oximetry) on monitors.
- Troubleshoot and adjust equipment as necessary.

Knowledge and Skills

- Knowledge of Pathophysiology of body systems and how anesthesia drugs affect each body system.
- Knowledge of nursing unit standards of care in the POCU/PACU and patient room areas.
- Knowledge of safety regulations along with policies and procedures (Universal Precautions).
- Ability to verbally communicate accurate data to doctors, surgeons, and anesthesiologists in a quick and thorough manner.
- Ability to write thoroughly enough for nursing care actions that could be defensible in a court system.
- Math skills to calculate IV drip rates, antibiotic dosages, to convert medication dosages to CCs from bulk medication containers, and to calculate appropriate pain medications.
- Reading skills to comprehend training manuals, physician orders, computer information, and data related to patient care in the POCU/PACU.
- Ability to effectively explain and train other nurses.
- Ability to prioritize nursing tasks according to standards of care in the POCU/PACU.
- Annual completion of specified mandatory in-services.

Physical Characteristics

- See well enough to read the space lab monitors and computers.
- Hear well enough to receive doctor's orders over the telephone and to hear monitor alarms at all times.
- Speak well enough to communicate ideas to doctors, other nurses, health care professionals, and family members.
- Strength to physically maneuver patients around in bed.
- Have use of hands and fingers to give injections, draw up medications into syringes, assist doctor with any procedures.
- Have mobility to move quickly in an emergency, to reach overhead and under beds, and to stand long periods of time.

Education/Experience

- Graduate of accredited registered nurse program.
- Valid registered nurse state license.
- BLS, ACLS, PALS certification within one year of employment.
- One to three years experience in CCU, ICU, ER and/or PACU preferred.

Additional Characteristics

- Flexible to work unscheduled hours as needed.
- Functions as a member of a multidisciplinary healthcare team, consults and collaborates with colleagues, peers, supervisors and other healthcare providers and promotes respectful relationships among colleagues.
- Delivers care in a non-judgmental, compassionate and nondiscriminatory manner that is sensitive to diversity.
- Delivers care in a manner that preserves and protects patient autonomy, dignity, respect and rights.
- Evaluates factors related to safety, effectiveness, and costs to the outcome of optimal patient care.
- Annual completion of specified competencies and in-services

_____

Employee Signature

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

June 12, 2014

OR equipment available for trauma procedures:

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

Community Health Network ANESTHESIA CALL SCHEDULE

June 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1 1st call BB 2nd call SBr 3rd call MG CVBB PD SBr	2 1stcallKM 2nd call TN 3rd call JG CHN lateJW CVSM PDKM	3 1st call LM 2nd call MT 3rd call JB CHN tatasw CVMT PDLM	4 1st call DC 2nd call SBr 3rd call MMY CHN late JS CVPK PO SBr	5 1st call KG 2nd call BB 3rd call MG CHN lateSB CVBB PD KC	6 1st call CM 2nd call KM 3rd call MPC CHN late SY CVMT PDKM	7 1st call JB 2nd call MPC 3rd call KM CVPK PDKM
8 1st can CM 2nd call KM 3rd call MPC CVMT PDKM	9 1St call JG 2nd call DC 3rd catl LM CHN late SY CVSM POJG	10 1st call SBr 2nd callAH 3rd call MSY CHN late DJ CVPK PDAH	11 1stcansw 2nd call JB 3rd call MMY CHN lateMPC CVSM POSW	12 1stcall TN 2nd call SY 3rdcall PK CHN lateKM CVPK POSY	13 1st call MSY 2nd call OJ 3rd callJG CHN lateCM CVDJ PDJG	14 1st call MMY 2nd call JG 3rd call OJ CVDJ PD JG
15 1st callMSY 2nd call OJ 3rd call JG CVDJ POJG	16 1st call SM 2nd call LM 3rd call SB CHN late JB CVSM PDLM	17 1st call ES 2nd call MG 3rd call AH CHN late DC CVPK PDAH	18 1st call DJ 2nd call KC 3rdcall MMY CHN late MT CVDJ PDKC	19 1st call KM 2nd call PK 3rd call JB CHN late BB CVPK PDKM	20 1stcaJlAH 2nd call MT 3rd call DC CHN late SBr CVMT PDAH	21 1stca11JW 2nd call DC 3rd call MT CVMT POJW
22 1stcallAH 2nd call MT 3rd callDC CVMT PDAH	23 1st call LM 2nd call MMY 3rd call BB CHN late KC CVBB PDLM	24 1st call SBr 2nd call ES 3rd call MG CHN late TN CVOJ PDSBr	25 1st call JW 2nd call eM 3rd call sw CHN late JG CVMT PDSW	26 1St call JB 2nd call BB 3rd call KC CHN late MMY CVBB PO KC	27 1st call TN 2nd call SY 3rd call SB CHN lateAH CVMT POSY	28 1st call MG 2nd call SB 3rd call SY CVOJ POSY
29 1st call TN 2nd call SY 3rd call SB CV OJ POSY	30 1st call MMY 2nd call AH 3rd call BB CHN late ES CVBB PDAH					

Community Health Network

ANESTHESIA CALL SCHEDULE

July 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
		1 1st call SM 2nd call SW 3rd call JS CHN lateCM CVSM PDSW	2 1st call ES 2nd call JW 3rd call OJ CHN late SBr CVDJ PDJW tvl'A:-oi.lt'	3 1st call SY 2nd call DC 3rd call MT CHN late SB CVMT POSY mR.-w+-	4 1st call JS 2nd call MSY 3rd call BB CVBB PO JS m -ov+	5 1st call SBr 2nd call BB 3rd call MSY CVBB PO SBr
6 1st call JS 2nd call MSY 3rd call 88 CV88 PD JS	7 1st call JG 2nd call TN 3rd call SB CHN lateSW CVDJ PD JG	8 1st call MG 2nd call JB 3rd call LM CHN late KM CVPK PDLM	9 1st call SW 2nd call ES 3rd carr MSY CHN lateAH CVBB POSW	10 1st call OJ 2nd call MMY 3rd call JS CHN late BB CVDJ PDJS	11 1st call PK 2nd call JW 3rd call KM CHN late TN CVPK PDKM ;:Hl-- out'	12 1st call SM 2nd call KM 3rd call JW CVSM PDKM
13 1stcallPK 2nd call JW 3rd call KM CVPK PDKM	14 1st call LM 2nd can ssr 3rd call MG CHN late MSY CVBB PO LM	15 1st call CM 2nd carl JS 3rd call SM CHN late OJ CVSM PO JS	16 1st call MS 2nd call SB 3rd call PK CHN late ES CVPK PDMS	17 1st call JG 2nd call SBr 3rd callJW CHN late MSY CVSM POJG	18 1st call JB 2nd calt SW 3rd call TN CHN lateSM CVBB PDSW	19 1st callMMY 2nd call TN 3rd call SW CVBB POSW
20 1st call JB 2nd call sw 3rd call TN CVBB PDSW	21 1st call AP 2nd call CM 3rd call PK CHN late RF CVPK PDAP	22 1st call MPC 2nd call MT 3rd call JR CHN late LM CVMT PDJR	23 1st call SW 2nd call MS 3rd call DC CHN lateMMY CVSM POSW	24 1St call MG 2nd callBB 3rd call RF CHN late JB CVBB PO RF	25 1st callKC 2nd callAH 3rd call MSY CHN JateMPC CVMT PDAH	26 1stcallJW 2nd call MSY 3rd callAH CVPK PDAH
27 1st call KC 2nd call AH 3rd call MSY CVPK POAH	28 1st call MT 2nd call MPC 3rd call MS CHN lateSB CVMT PDMS	29 1st call DC 2nd call JR 3rd call ES CHN lateAP CVBB PD JR	30 1st call RF 2ndcallJW 3rd can OJ CHN late SW CVDJ PDJW	31 1st call TN 2nd call AP srd call JB CHN lateMS CVBB PDAP		

Community Health Network

ANESTHESIA CALL SCHEDULE

August 2014

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1 1st call MT 2nd call MMY 3rd call JR CHN late DC CVMT PDJR	2 1st call BB 2nd call JR 3rd call MMY CVBB PDJR
3 1st call MT 2nd call MMY 3rd call JR CVMT PDJR	4 1st call MPC 2nd call CM 3rd call KC CHN late AH CVBB PDKC	5 1st call SM 2nd call MSY 3rd call KM CHN late JM CVSM PDKM	6 1st call SW 2nd call MT Srd call SY CHN late BB CVMT PDSW	7 1st call CM 2nd call OJ 3rd call JW CHN late MPC CVDJ PDJW	8 1st call DC 2nd call KC 3rd call JB CHN late KM CVMT PDKC	9 1st call MSY 2nd call JB 3rd call KC CVJM PDKC
10 1st call DC 2nd call KC 3rd call JB CVSM PDKC	11 1st call JR 2nd call JM 3rd call MS CHN late SY CVJM PD JR	12 1st call PK 2nd call JG 3rd call SBr CHN late OJ CVPK PD SBr	13 1st call JS 2nd call SB 3rd call MPC CHN late LM CVMT PDJS	14 1st call MSY 2nd call SY 3rd call DC CHN late KC CVDJ PDSY	15 1st call JG 2nd call PK 3rd call RF CHN late MT CVPK PDJG	16 1st call SBr 2nd call RF 3rd call PK CVPK PD SBr
17 1st call JG 2nd call PK 3rd call RF CVPK PO JG	18 1st call JS 2nd call DC 3rd call SB CHN late TN CVDJ PO JS	19 1st call AH 2nd call MG 3rd call MT CHN late ES CVMT PDAH	20 1st call SW 2nd call SM 3rd call TN CHN late CM CVSM PDSW	21 1st call PK 2nd call MPC 3rd call JG CHN late DC CVPK PDJG	22 1st ca11 DJ 2nd call ES 3rd ca11 AP CHN late SY CVDJ PDAP	23 1st call MT 2nd call AP 3rd call ES CVMT PDAP
24 1st call OJ 2nd call ES 3rd ca UAP CVDJ PDAP	25 1st call KM 2nd call JS 3rd call SY CHN late MS CVSM PDKM	26 1st call JM 2nd call RF 3rd call CM CHN late SM CVJM PDRF	27 1st call ES 2nd call MS 3rd call BB CHN late MT CVBB PDMS	28 1st call MPC 2nd call KM 3rd call JS CHN late AP CVDJ PDJS	29 1st call SB 2nd call LM srd call JM CHN late JB CVJM PDLM	30 1st call CM 2nd call JM srd call LM CVJM PDLM
31 1st call SB 2nd call LM 3rd call JM CV JM PD LM	1st 1st JB 2nd DJ 3rd KM CV DJ PDKM					

Anesthesia

Name	Initials
Beachkofsky, Joel	JB
Beall, Scott	SB
Birrer, Steve	SBr
Burke, Brent	BB
Caldwell, Michael	MPC
Camp, David	DC
Clinkenbeard, Kristin	KC
Fredericks, Ron	RF
Good, Jason	JG
Guzman, Mike	MG
Harrity, Andrew	AH
Hennessee, John	JOH
Hogshire, Jan	JH
Jones, Dan	DJ
Kane, Paul	PK
LeBree, Jen	JL
Makino, Kotaro	MK
Marti, Blake	BM
Maves, Steve	SM
Moore, Leslie	LM
Munro, Jonathan	JM
Murphy, Meera	MMY
Myers, Chuck	CM
Novak, Tom	TN
Powell, Andrew	AP
Ramolia, Neil	NR
Schlabach, Ervin	ES
Sherrill, Mike	MS
Spoljoric, Jason	JS
Strnad, Rene	RS
Thomas, Mike	MT
Vore, Scott	SV
Walton, James	JW
Walton, Shanna	SW
Yacko, Mark	MMY
Yacko, Mike	MSY
Yitta, Sushma	SY
Zynger, Linda	LZ

CV: Cardiac Call
PD: Pediatric Call

QUALITY/SAFETY MANAGEMENT PLAN
SURGICAL SERVICES

Community Hospital North

August 2013

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Quality/Safety Management Plan
Surgical Services

I. Mission/Vision/Values Statements

Mission

The mission of Surgical Services is to be a leader in providing a full continuum of services to the community serviced by the Community Health Network. We will be central Indiana's most preferred inpatient and outpatient surgical service provider and we will deliver unsurpassed service to our physicians and their patients. In partnership with our medical staff, we offer innovative and individualized surgery options that are responsive to our customer's needs. We are committed to efficiently and safely delivering the highest quality surgical care, creating an exceptional experience for physicians, patients, families and employees.

Vision

Community Hospital North Surgical Services will deliver unsurpassed service to our physician and their patients. In partnership with our medical staff, we offer innovative and individualized surgery options that are responsive to our customers' needs and improve their health and well being. We are committed to efficiently and safely delivering the highest quality surgical care, creating an exceptional experience for patients, families, physicians and employees..

Values

1. Safety
2. Responsiveness
3. Partnership
4. Excellence
5. Efficiency

II. Types and ages of patients served

Surgical Services provide services tailored to the special needs based on age: infants, children, adolescents, adults, and senior adults. Interventions are provided throughout the continuum with the exception of major organ transplantation and cardiac.

III. Scope and complexity of need; extent to which needs are met

Services are designed for all levels across the health continuum. Services include education and consultation from pre-procedure planning to discharge follow-up.

The continuum of care is comprehensive and includes but not limited to:

- Community Support
- Consultation

- Education
- Home Health
- Inpatient
- Outpatient
- Pre-operative Clinic
- Wellness

Unit Description

8	Operating rooms approximately 650 square feet each
15	Private preoperative rooms (two can swing to PACU rooms)
5	Private dedicated PACU rooms (total of 8 if utilizing 2 pre-op rooms noted above)
2	2 of the above 21 rooms able to care for isolation patients
1	Assisted fertility laboratory

Pre-op Clinic

The pre-operative clinic offers pre-admission testing/screening and education for patients up to seven days prior to their surgical procedure. If requested by the surgeon, or necessitated by patient condition, the patient may be seen by a Hospitalist/Intensivist or the patient's chart may require further review by an anesthesiologist in order to be cleared for surgery. Depending upon availability, Same day appointments can be made by calling 317-621-5152.

Surgery Preoperative Care Unit

The RN receives and admits the patient to the unit. The patient is initially identified using at least two patient identifiers. The RN performs an assessment on each patient who is admitted through this unit. This assessment includes the identification of the patient's physical, psychosocial, spiritual and economic needs. The RN also obtains a complete health history by utilizing advanced interview techniques, including the use of open-ended questions to gather date. Labs, x-rays, EKG and other tests are ordered based on direction from the Surgeon, Endoscopist and/or Anesthesiologist/physician. All verbal and/or telephone orders are verified by the RN utilizing the RAV (read-back and verify) system. Pre-procedure teaching is done by the RN with the patient, and/or their family/significant other. This educational component includes, but is not limited to, the process that is utilized to ensure the patient's safety, such as repetitive questioning regarding allergies, type of procedure, and patient cart rails in place. The patient is apprised of what can be expected from the Anesthesiologist/physician such as meeting him/her pre-procedure, having an IV started (if not already in place), and the process of anesthesia sedation. The patient is also educated regarding the stay in PACU if appropriate. The RN discusses the discharge instruction sheet and reinforces those areas that are specific to the patient and his/her procedure. Although there is a basic teaching plan in place, education is individualized to address those previously assed needs. The patient acknowledges understanding of the instruction verbally and by signing the instruction sheet. Any potential problems that are identified are addressed by the RN pre-procedure. These potential problems include but are not limited to the need for crutches or walker, no ride home, or no responsible person to stay with the patient at home.

Pre-procedure medications are administered and IV fluids are initiated by the RN/ as ordered by the Anesthesiologist and/or Surgeon. The RN/ ensures that consent for the procedure has been obtained prior to administering pre-operative medication to the patient. Any relevant information regarding a patient's special need is communicated verbally to the Operative Room RN and PACU RN utilizing the "hand-off" approach in addition to documentation of the same.

A systems approach is utilized when the RN performs the assessment of a patient prior to a procedure. Baseline vital signs, including temperature, pulse, respiration, and blood pressure measurement are obtained. Pulse oximetry and cardiac monitoring are available as necessary. A re-assessment is performed as deemed necessary by the RN based on subjective and objective data. An RN is always in attendance/available when a patient is present in the unit.

Surgery

All patients undergoing a surgical procedure are assigned a minimum of one circulating registered nurse and one scrubbing registered nurse or certified/ surgical technician. Additional circulators and scrubs are provided based upon the acuity/complexity of the procedure, physician request, and/or use of special equipment such as a laser. AORN Recommended Standards will be utilized as guidelines for safe optimal staffing and practice within the operating room setting. A Board Certified or Board Eligible Anesthesiologist provides all anesthetics within the surgery setting. On-site nursing staff is provided 24/7 Monday through Sunday. The number of onsite staff varies between days, evenings and weekends. Additional staff is on call evenings and weekends to meet emergent surgery needs. Ideally, cases are scheduled between 8 am and 5 pm. However, scheduled cases may be requested to begin as early as 7 a.m. and end as late as 6 p.m. Special requests outside these times are honored on a case by case basis as resources are available. Add-on cases are performed on a case-by-case basis based upon the current surgery schedule at the time of request.

PACU

Level of Care I

The Handoff Communication Process is continued at this time. The PACU RN receives a verbal report from the Anesthesiologist and Circulator as she/he accepts responsibilities for the patient's care. The RN performs an initial assessment and documents the findings. The assessment includes, but is not limited to, patency of airway, respiratory rate and depth, blood pressure readings, condition and color of skin, patient safety needs, neuromuscular status, presence and condition of drainage tubes and catheters, dressings on operative sites, location and condition of IV sites and lines, assessment and documentation of input and output, Aldretti type score, and level of emotional and physical support needed This assessment is ongoing during the patient's PACU care. The RN re-assesses the patient every 15 minutes during PACU care, but may perform a re-assessment more frequently if condition warrants. All RNs delivering care are ACLS and PALS certified.

A certain level of competence is required by all RNs delivering this care, therefore each is competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient's classification, each patient receives care on the basis of assessment of needs.

Re-assessments are performed with any change in condition, cardiac rhythm and post-invasive procedure. The data obtained is interpreted and documented by the RN. Nursing actions and/or interventions with outcomes are documented. The RN collaborates with the Anesthesiologist and/or Surgeon as appropriate. All orders are read-back and verified with the ordering physician.

When a patient has met discharge criteria, but their bed is unavailable, reassessments and vital signs will be completed every thirty minutes.

Those patients whose total care requires expertise and resources that are unavailable at CHI will be stabilized, treated, and transferred to the appropriate facilities.

Level of Care II
The level of care occurs in the same area as PACU Level of Care I. Patients who have only received local or IV sedation immediately enter a PACU Level of Care II. Families are able to join the patients during this phase of their care. Discharge instructions are reinforced with patient and family by the RN and a written copy is sent home with the patient.

A complete assessment utilizing a systems approach is performed by the RN on each patient upon entering the PACU Level of Care II status and prior to discharge. Reassessments are done as necessary with any change in condition or previously assessed parameters. Cardiac monitoring and pulse oximetry capabilities are available if necessary. If a patient's condition warrants, he/she will be transferred to PACU Level of Care I.

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

Surgical services are provided by a multi-disciplinary professional team which includes but not limited to:, Hospitalists/Intensivists, Surgeons, Anesthesiologists, RNs, Certified Surgical Technologists. Student Nurse Externs, Support Technicians, Patient LiaisonsVolunteers. In addition, support is provided by: Respiratory Care, Pharmacy, Radiology, Laboratory, Nutrition, Physical Therapy, Social and General Services, Materials Management, Finance and Information Systems as needed in a timely manner.

The administrative staff for Surgical Services includes: the Executive Director, Medical Directors, Clinical Director, Team Leaders/Coordinators,

Availability of necessary staff

Surgery pre-procedure area

A modified Primary Nursing model for delivery of care is utilized in the pre-procedure care unit. The RNs are cross-trained to work in the admission, and recovery areas. All are required to maintain a level of competence. The RN is competent to admit, assess and administer care to a pre-procedure patient of any level of acuity or complexity. If the patient's identified needs require more nursing resources and additional RN/ is utilized to assist. Support personnel are available to assist the RN/. This unit is routinely staffed by RNs Monday through Friday 5:00 a.m. – 9:30 p.m.

Surgery

All procedures are assigned a minimum of one monitoring/circulating RN. Demands of each procedure room schedule will be optimally matched with skills and expertise of assigned competent staff. Assignment of additional personnel will be provided as necessary with consideration to:

- Need for hospital scrub, RN, , CST
- Acuity/complexity or procedure
- Physician request
- Special equipment, i.e., laser

One trained laser nurse will be assigned to each laser procedure with exclusive responsibility to laser operations the exception being laser ophthalmic procedures. General anesthesia services are provided by Anesthesiologists. The surgical area is open for routine procedures from 7:00 a.m. – 11:30 p.m. Monday through Friday,. Outside of normal working hours emergency coverage is provided by on-call teams.

PACU (Phase I and II)

PACU I utilizes a modified Primary Nursing model for delivery of care. With this model an RN takes primary responsibility for assessing and addressing a specific patient's needs during his/her stay in the PACU. A Charge Nurse is assigned on a daily basis to coordinate care and activities. Primary care is delivered by an RN. All PACU RNs are ACLS and PALS certified with re-certification completed biannually.

A certain level of competence is required by all RNs in the PACU, therefore, each is deemed competent to care for a patient of any acuity/complexity. Although assignments of patients are based on ASPAN standards for patient classification, each patient receives care on the basis of assessment of needs. Clinical technicians assist with designated duties under the directions of the RN.

PACU II utilizes a modified Primary Nursing model that also represent the care delivery system in PACU I. All RNs are required to maintain a level of competence to provide care to a patient of any level of acuity or complexity. Support personnel are available to assist the RN. Assignment of care is based individually on the assessed patient needs.

This unit is routinely staff Monday through Friday 5:00 a.m. – 11:30 p.m. Outside of working hours care is provided by on-call teams.

VI. Standards/Guidelines for Surgical Services Practice

Standards and Guidelines for Practice are utilized to provide care and include but are not limited to the following:

- Patient Care Pathways
- Professional Practice Model
- Patient Rights Handbook

- Advanced Practice Committee Guidelines/Recommendations
- Unit based guidelines for patient care that include:
  - ASPAN
  - AORN
  - SGNA
- Hospital Policy and Procedures
- External Regulatory Standards

VII. Methods to assess and meet patient needs

- Nursing process
- Admission assessment forms
- Risk screens/pre-admission clinic
- Pathway implementation
- Patient satisfaction surveys
- Follow-up phone calls
- Cost comparisons
- LOS comparisons
- Outpatient admission rates
- Review scope of care (III and IV)

VIII. Identification of MAJOR internal and MAJOR external customers

Internal
- Employees
- Physicians

External
- Payers/employers
- Patients/significant others
- Community

IX. Patient/significant other education

Teaching protocol

This education will be age specific to include the following:
- Patient rights and responsibilities
- Estimated or schedule time for surgery/procedure
- Monitors to be utilized patient identification protocol
- Anesthesia related teaching by appropriate professionals, i.e., Registered Nurse, Anesthesiologist
- Explanation of peri-operative environment and safety procedures
- Post procedure destination

- Usual recovery time with exceptions and patient/family participation expectations
- Time and location family/significant other may resume visitation
- Assurance that needs will be met, i.e., warm blankets, pain relief and antiemetic therapy.
- Possibility of O_2 therapy per their need
- Instruction of pain scale 0 – 10
- Validation of understanding patient/family/significant other of education with documentation
- All other educational needs will be individualized as needed per specific procedure, i.e., SCDs, PCAs, crutch training and drains
- All education is reinforced to patient, family and significant other prior to discharge and documented on appropriate form per unit protocol

See Scope of Care (III and IV for individualized unit patient education)

Education tools

- Videos
- Pathways
- Tours
- Handouts

Home Care

- Education built into pathway

Surgical Services patient follow-up

- Outpatient procedures will receive a follow-up phone call within 24 – 48 hours of working business days. This will give the patient customer opportunity to voice questions, allow reinforcement of physician direction and identify satisfactions as well as opportunities for improvement
- A letter will be sent to those outpatients who are not reached 24 – 48 hours of working business days post procedure by phone after 2 attempts
- Opportunities for improvement are specifically identified through patient satisfaction questionnaires

Community Hospital North

Indianapolis, Indiana

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

SECTION 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."

NARRATIVE RESPONSE AND DISCUSSION

Section 12 is met with a letter of commitment from Dr. Bruce Ackerman, Medical Director of Critical Care at Community North Hospital, affirming that critical care coverage is available twenty four hours per day.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 North in the 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 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,

6/4/14

Bruce Ackerman, M.D.
Medical Director of Critical Care

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Providers/Employees

Community Health Network

Ranked among the nation's most integrated healthcare systems, Community Health Network is Central Indiana's leader in providing convenient access to exceptional healthcare services, where and when patients need them—in hospitals, health pavilions, workplaces, schools and homes.

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Bruce Ackerman, M.D.

Critical Care Medicine (Board Certified), Internal Medicine (Board Certified), Pulmonary Disease Medicine

Community Physician Network doctor

Request Appointment

Education: Jefferson Medical College

Internship: Mercy Hospital of Pittsburgh

Residency: University of Pittsburgh Medical Center

Age: 49

Gender: M

Office Locations

Pulmonary and Critical Care
1400 North Ritter Avenue
Suite 375
Indianapolis, IN 46219
P: 317-355-9370
F: 317-355-9395

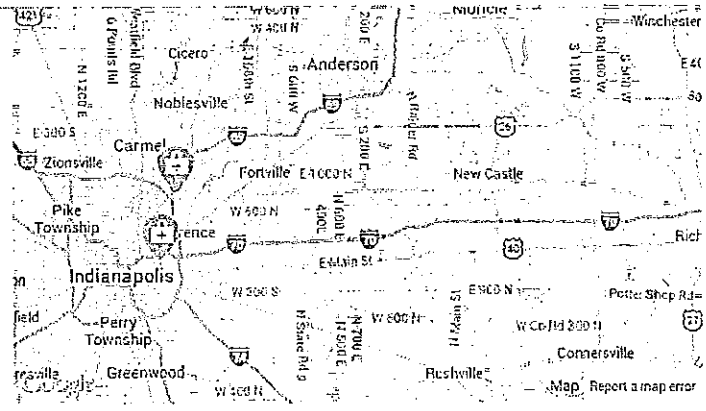
Mon: 8:30 AM - 5:00 PM

Tues: 8:30 AM - 5:00 PM

Wed: 8:30 AM - 5:00 PM

Thurs: 8:30 AM - 5:00 PM

Fri: 8:30 AM - 5:00 PM



Community Hospital North

Indianapolis, Indiana

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

SECTION 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"

NARRATIVE RESPONSE AND DISCUSSION

Section 13 includes written letters of commitment from Community Hospital North's Radiology Medical Director and the Radiology Administrative Director. There are also copies included that show the twenty four hour availability of conventional radiology, CT, and X-ray services.

Community
Health Network

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 North in the 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 North twenty-four hours per day. Our CT and X-ray technologists will respond to all Trauma Level One activations.

Respectfully,

Tom Young, MHA, RT(R)(CT)(MR)
Community Hospital North
Radiology Administrative Director

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community
Health Network

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 North in the 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 North twenty four hours per day. Our CT and X-ray technologists will respond to all Trauma Level One activations.

Respectfully,

Bryan Hankins, MD
Chief of Radiology - Community Hospital North

Joseph Pavlik, M.D., FACS
Trauma Medical Director

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action		
6/01/14	Reviewed			Effective	6/01/14
				Major Change	_____
				Minor Change	_____
				New Policy	6/01/14
				Cancels	_____

TITLE: **ED PATIENT CT SCANNING**

STATEMENT OF PURPOSE: To clarify scope of services for CT equipment, CT Technologists, and Radiologists.

TEXT: The CT scanner, located in the Medical Imaging Department, is available 24/7 and staffed 24/7 with a CT technologist.

1. All scans at Community Hospital will be performed under the general supervision of a staff radiologist.
2. Scans will be transmitted via the telerad system (PACs) to the Radiologist.
3. Intravenous administration of contrast will be done only under the directive of a staff physician or Radiologist and will be injected by a Radiological Technologist. 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 rooms.
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.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK
MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE
APPROVED FOR:

☑CHE ☑CHN ☑CHS ☑CHVH

Date	Action	Date	Action		
6/01/14	Reviewed			Effective	6/01/14
				Major Change	____
				Minor Change	____
				New Policy	6/01/14
				Cancels	____

TITLE: **QUALIFICATIONS AND RESPONSIBILITIES OF THE RADIOLOGISTS**

STATEMENT OF PURPOSE: To set forth qualifications and duties of the Radiologists.

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 (6) months of formal dedicated training in the interpretation and form 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.
2. The physician should have documented training and understanding of the physics of diagnostic radiography and of the equipment needed to safely produce images. This should include plain-film radiography, film-screen combinations, conventional image processing and where applicable, digital image processing.
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.
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.
5. Certification in Radiology and/or Diagnostic Radiology by the American Board of Radiology, and/or American Osteopathic Board of Radiology or as credentialed by the medical staff office.
6. All Physicians practicing diagnostic Radiology are members of the medical staff. Their credentials, located in the Medial Staff office, reflect their experience and current competency requirements for all aspects of Radiology services in which they are engaged.

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 the 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).

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

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Date	Action	Date	Action		
6/1/14	Reviewed			Effective	6/01/14
				Major Change	____
				Minor Change	____
				New Policy	6/01/14
				Cancels	____

TITLE: **TELERADIOLOGY**

STATEMENT OF PURPOSE: Scope of service to provide transmission and viewing capability of medical imaging procedures to an off-site location.

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 procedures.

The goals of teleradiology are:
1. To provide consultative and interpretative radiological services.
2. To facilitate radiological interpretations in any situation.
3. To provide direct supervision during off-site situations.

In the event that the teleradiology system is inoperable the following should be done:
1. The PACs administrator should be notified.
2. If necessary, service calls to the appropriate vendors will be made by the PACs administrator on-call.
3. The Radiologist will provide on-site interpretation or consultation services, as needed, following notification of the problem with the teleradiography system.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

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Date	Action	Date	Action		
6.1.14	Reviewed			Effective	6.1.14
				Major Change	____
				Minor Change	____
				New Policy	6.1.14
				Cancels	____

TITLE: **Emergency Department Radiologic Examinations (X-ray)**

STATEMENT OF PURPOSE: To set forth guidelines for the safe, efficient service for the Emergency Department. As performed by Radiologic Technologist, and Radiologist.

1. Radiology (X-ray) is available 24/7 on-site with additional X-ray staff available on-call as needed.
2. Appointments for Emergency Department patients are not necessary. When applicable, ED patients will be radiographed in the ED room with portable X-ray. If there is not a technologist in the X-ray department when an ED patient is ready, the X-ray technologist will be notified via vocera or mobile phone by the ED department.
3. Emergency department patients will be done in the order the exam are placed "ready" in EPIC, unless otherwise directed by the ED staff.
4. Whenever possible, ED patients will take precedence over inpatients and out patients.
5. If it is necessary for the patient to be transferred to another hospital CD images will be provided upon the EDs request.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

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Date	Action	Date	Action		
6/01/14	Reviewed			Effective	6/01/14
				Major Change	_____
				Minor Change	_____
				New Policy	6/01/14
				Cancels	_____

TITLE: **RADIOLOGIST COVERAGE**

STATEMENT OF PURPOSE: Scope of service for staff Radiologists and to provide adequate medical coverage to meet customer needs.

Irvington Radiologists provide coverage for the Radiology Departments of Community Health Network.

1. Radiologists are present in the hospital from 8:00 AM to 4:30 PM and from 4:30 PM to 8:00 AM a Radiologist is present on-site at one location and is available via phone 24/7.
2. Radiologists are always available for consultation with ordering physicians 24/7.
3. All Physicians practicing diagnostic Radiology are members of the medical staff. Their credentials, located in the Medial Staff office, reflect their experience and current competency requirements for all aspects of Radiology services in which they are engaged.

Formulated by: Medical Imaging Directors
Reviewed by: ED Trauma Coordinator

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

APPROVED FOR:

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Date	Action	Date	Action		
				Effective	2/93
8/05	Revised	8/95	Reviewed	Major Change	08/05, 11/07
11/07	Revised	12/97	Revised	Minor Change	08/12, 03/13
02/10	Revised	2/99	Reviewed	New Policy	_____
03/12	Revised	2/01	Revised	Cancels	_____
08/12	Revised	1/03	Revised		
03/13	Revised				
06/14	Reviewed				

TITLE: **REPORTING EXAM RESULTS**

STATEMENT OF PURPOSE: To describe the mechanisms/processes for communicating and distributing exam or procedural results that are in preliminary or final status.

1. EMERGENCY DEPARTMENT REPORTS

After exam completion, the digital image is electronically sent to PACS where it is immediately available for viewing by the radiologist and other physicians with PACS access (includes ED physicians, staff physicians and cardiovascular surgeons). These images, which are always treated as "STAT," are interpreted promptly by Radiologists (24-7) via voice recognition. (At Community South, ED physicians initiate wet-reads during the hours of 1 a.m. – 6 a.m.).

The preliminary/final reports become available in PACS and are viewed by the network Emergency Department physicians.

Exception – Community Hospital South during night shift hours: At CHS, "Night Hawks", an independent radiology group, is contacted to view advanced modality images, sent from CHS Radiology. A requisition specific to Night Hawks is faxed to them to obtain a preliminary reading. After interpretation, the Night Hawk radiologist sends a faxed report back to the Community South technologist. This is matched up with the CHI Medical Imaging Requisition and given final interpretation the next day by Radiology Associates of Indiana (RAI). Diagnostic X-rays will receive a preliminary interpretation by the Emergency Department physician, and a final interpretation is made the following morning by RAI radiologists.

2. ALL STATS

All "Call Reports, Hold & Calls, and "fax to" actions are documented in **Exam Memo** (in PACS) by the Imaging Support staff.

3. OUTPATIENTS

After exam completion, all routine outpatient exams/procedures are generally dictated within 24–48 hours with few exceptions (awaiting more images, etc.). However, any completed exam, not read by the following business day, is tracked in the Imaging Record Room as a quality indicator. Resolution to any unread exam is promptly brought to the Radiologist's attention.

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

☑CHE ☑CHN ☑CHS ☑CHVH

4. INPATIENTS

All STAT, Call Doctor and/or Hold & Call requests will be interpreted within the approved guidelines. Any off-site comparisons will follow as an addendum. STAT and "call report" exams are called to the nursing unit by the imaging record room staff or, in some cases, by the technologists. This communication is documented in PACS "Exam Memo." For critical results on a routine inpatient exam – the ordering physician and/or patient nurse (RN) will be called immediately by the radiologist. All inpatient exams are monitored to ensure that all exams receive, at minimum, a preliminary result within 24 hours.

5. EMERGENCY BACK-UP IN THE EVENT OF NETWORK PACS FAILURE

Should there be complete failure of the digital image management system (PACS), the radiologist on-site will begin to interpret from hard copy film or modality workstation. **If no radiologist is on-site, the "on-call radiologist" will be notified to come in.*

6. DISCREPANCIES

If at any time a discrepancy is noted from the original preliminary or final report, a corrected interpretation will be dictated, with prompt communication to the ordering physician.

7. CRITICAL RESULT REPORTING

Critical Results are defined as potential life-threatening or serious findings that need reported to the ordering physician immediately. Community Health Network, along with the radiologists, has designated specific criteria/results that get monitored and audited. This doesn't exclude the fact that "other" critical results occur and are dealt with accordingly. Regardless of type of patient *(Inpatient, Outpatient, ED patient, Imaging Centers, Medchecks, Community Heart and Vascular Hospital)),* critical results will be called immediately (not to exceed 30 minutes of the radiologist's interpretation time. They are to be called to the ordering physician or licensed caregiver (MD, DO, P.A., N.P, RN). **The call is to be made by the interpreting radiologist**. If the receiver is an R.N., they will be asked to "read back and verify" the results. The name of the person receiving the result, their title and the time of the call is required to be dictated, by the radiologist, within the body of the report.

The radiologist, in conjunction with input from other medical sections, will maintain the list of critical result criteria and make changes as necessary or with recommendations from other medical staff departments. The imaging department will track compliance with the defined 30 minutes turn-around- time. This data will be reviewed daily and analyzed. The data collected will be put in a monthly audit report. This report is shared with Hospital Quality Assurance and the Radiologist's Section Chairman (CHE-CHN-CHVH and CHS).

COMMUNITY HEALTH NETWORK

MEDICAL IMAGING DEPARTMENT POLICY AND PROCEDURE

☑CHE ☑CHN ☑CHS ☑CHVH

8. REPORT DISTRIBUTION

Reports are digitally stored in Phillips PACS (Archive) for permanent retrieval. Health Information Management (Medical Records) receives an electronic copy for the patient's electronic medical record. A copy of the report also is delivered to the ordering physician via electronic distribution, mail, courier, or auto fax.

See * Attachment "A" – Critical Results Reference Revised – 01/2012

Formulated by: Deb Hayden & /Kathy Steffen

ATTACHMENT "A"
CRITICAL RESULTS REFERENCE

- New Pulmonary Embolus
- Ruptured Aortic Aneurysm
- New Aortic Dissection
- New Intracranial Hemorrhage
- Potentially Life-Threatening Hemorrhage - any location
- Acute appendicitis
- New Unexplained/Unexpected Pneumothorax – MD decision to call if critical!
- Ectopic Pregnancy
- Testicular torsion
- Ovarian Torsion
- Potentially Life-Threatening Tube or Line Malposition/Misplacement - Pneumotosis Intestinalis – MD decision to call if critical!
- Pneumotosis Intestinalis
- Pneumopericardium
- Cervical Spine Fracture

Review/Revision: January 2012

Dictation Criteria: Please follow instructions below for dictating critical results:

1. Call report immediately, or within 30 minutes of interpretation (*J.C. Rule*)
2. Reports must be called to one of the following caregivers : MD, DO, PA, NP, RN
3. In the "IMPRESSION" – radiologist to include:
   - Dictate "CRITICAL OUTCOME"
   - Dictate "NAME" of person called (*no informal titles*)
   - Dictate "TIME" called
   - Dictate "RAV" was performed with an RN

Note the following:

- No time given of call – equates to non-compliance.
- RAV with MD, NP, DO, or PA – is assumed through dialogue.
- RAV with RN – radiologist should verbally acknowledge and have RN read-back understanding of the critical outcome before ending the call.

4. Important!!! – Click and drag the study to the Critical Result Folder in IDX so a faxed report can be sent as follow-up.

Community Hospital North

Indianapolis, Indiana

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

SECTION 14

Intensive Care Unit

"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

Section 14 includes signed copies of the Community North ICU policies and equipment list. The ICU Nursing Director has also included a letter of commitment affirming a maximum ration of 2:1 for trauma patients.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 Nursing of the Intensive Care Unit. I am pleased to support Community Hospital North in the effort to complete "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,

Elsie Broda RN,

Elsie Broda, RN
ICU Nursing Director of Critical Care

Joseph Pavlik, M.D., FACS
Trauma Medical Director

ICU Staffing Grids 2014

		Staffing	DAYS	3P-7P	7P-11P	Nights	Prod hrs/pt Day	With Manager
# of PTS								
24		RN	14	14	14	14	17	17.33
		PSP	3	3	3	3		
23		RN	14	14	14	14	17.74	18.09
		PSP	3	3	3	3		
22		RN	13	13	13	13	17.45	17.82
		PSP	3	3	3	3		
21		RN	13	13	13	13	18.28	18.67
		PSP	3	3	3	3		
20		RN	12	12	12	12	18	18.4
		PSP	3	3	3	3		
19		RN	12	12	12	12	18.94	19.37
		PSP	3	3	3	3		
18		RN	11	11	11	11	18	18.44
		PSP	3	3	2	2		
17		RN	10	10	10	10	17.41	17.88
		PSP	3	2	2	2		
16		RN	9	9	9	9	16.5	17
		PSP	2	2	2	2		
15		RN	9	9	9	9	17.16	18.13
		PSP	2	2	2	2		
14		RN	8	8	8	8	17.14	17.71
		PSP	2	2	2	2		
13		RN	8	8	8	8	18.46	19.07
		PSP	2	2	2	2		

Community Hospital North
Intensive Care
Guidelines for
Patient Care & Practice Delivery

Assessment:

1. Admission Assessment and Admission database completed within 8 hours of arrival to unit in the Admission Navigator. Items not completed in that period can be passed on to the next shift. The admission database should be completed within 12 hours of admission.
2. Complete "Head-to-Toe" physical assessment will be done at the beginning of each shift *for all levels of care. Exceptions are patients who are receiving end of life care, experiencing a procedure or patients needing uninterrupted sleep. Patients transferring from any inpatient unit will have a complete head to toe physical assessment with a comprehensive skin assessment completed within the first **hour** of admission by an RN.
3. Based on the patient's primary diagnosis, presenting symptoms, course of treatment and therapies, the RN will determine the components of reassessment. The repeat assessments will be done according to Level of Care/Accommodation Code Policy (CLN-2081). Only changes from the beginning of shift* assessment need to be documented.
4. Complete System's Review is in accordance with Epic "Row Information"
5. Braden Score/Assessment/Morse Fall will be completed a minimum of every shift. Interventions will be developed as necessary and documented in plan of care.
6. Patient will be weighed on admission and every 24 hours by 0600
7. Sepsis screening will be completed every shift and documented on flow sheet.
8. Patients with an indwelling urinary catheter will be reassessed for need every 8 hours and PRN.
9. Upon admission or transfer into the unit, nasal MRSA swabs will be completed.

*A shift is defined as a continuous period longer than 3 hours in which one particular RN directs care.

Vital Signs/Wave Forms:

1. Apical heart rate (AHR), blood pressure, respirations, oxygen saturation, temperature and urinary output will be assessed and recorded every 2 hours.
2. Oral temperature will be assessed and recorded every 4 hours unless abnormal. If oral route is not accessible, then a rectal route is preferred. Axillary temperatures should be avoided.
3. Blood pressure and/or AHR will be documented with vasoactive medication titration /management to a frequency at least every 15 minutes while documenting post intervention effects. "Stable" patients on vasoactive medication will have vital signs assessed and recorded every hour. Vasoactive medications will be titrated to the minimal amount of medication to maintain the desired prescribed effect.

4. EKG values will be documented at the start of each shift with any EKG changes documented throughout shift. Patients will be monitored in 2 leads at all times at the bedside and at nurse's station (one of the leads must be V lead unless contraindicated).
5. Cardiac monitor alarms will be "individualized" for patient parameters. HR and BP boundary alarms should be set 20 above and 20 below current rate.
6. ST alarms must remain on with exception of patients in atrial fibrillation or paced rhythm.
7. Waveforms of invasive monitoring (arterial, PA, ICP, abdominal pressure monitoring) will be documented every shift and when clinically significant changes noted.
8. Patients who are downgraded to a lower level of care will have their vital signs monitored and recorded according to their specific level of care (Level of care Accommodation Code Policy) (CLN-2081) and according to nursing judgment.

Standard Room Setup:

Prior to admission, the room is to be readied and include, but not limited to:

1. Bed zeroed with 1 top sheet, 1 fitted sheet, 1 pillow, and gown.
2. 02 regulator in place.
3. 2 suction heads with canister and tubing available
4. Ambu Bag
5. Yankauer suction tip (2)
6. IV pole and infusion pump (still in plastic bag).
7. New blood pressure cuff, SaO2 probe and electrodes connected to monitor cable.
8. Room stocked and clean linens in drawers.
9. Locked medication drawer emptied of contents and cleaned.
10. Blank charge sheet

Shift Report:

Bedside rounds will occur and are documented at each change of shift by RNs (using the "Take Five" method)

Introduction of oncoming staff to patient and/or family

Identification of patient with name and date of birth and validating information matches arm band

Rounds will include:

1. Complete IV system check
   a. Channel labels and guardrails
   b. Correct fluid rate (to include current dosage of any vasoactive or sedative medication in respect to goal)
   c. Correct patient
2. Complete system check on any infusion
3. Monitor alarm checks
4. Verification of ETT cm marking, PA catheter cm Marking, ICP placement security/EVD level (mmHg or CM H2O)
5. Inspection of all surgical/invasive line dressings/drains, if applicable
6. Glascow Coma Scale and NIH stroke scale on all patients with a neurological diagnosis

7. Check oxygen/ventilator settings
8. Verify HOB at 30- 45 degrees unless specifically ordered
9. Review of Plan of Care via active order sets, patient history, and outcomes.
10. Review of current labs along with interventions, if applicable
11. Review of medications in EPIC
12. Completion/review of code record and/or advance directives
13. Completion of restraint documentation per policy
14. Review of doctor's orders from previous shift
15. Check armbands/allergies
16. Sign-off in "Sign Out Report" within EPIC "Orders reviewed and patient rounding completed" followed by names of on-coming and off-going RN's.
17. Sign off on the controlled substance form when applicable

Transport/ Monitors:

1. All patients admitted to a monitored bed with an Intensive Level of Care (or higher, according to the Level of Care/Accommodation Policy) will be monitored during transport unless a specific order has been written that the patient may be transported without a monitor
2. All patients classified with a level of care greater than progressive care will be accompanied by a RN during transport
3. Monitor and other device alarms will be on at all times

Mobility:

1. Mobility will be attained by utilization of the mobility protocol and documented.
2. All patients with Braden score <17 will be placed on a waffle mattress.
3. All patients will be up in a chair at least BID daily unless contraindicated by physiologic instability or specific physician order or document rationale for not getting patient up in chair.
4. HOB will be kept at a minimum of 30 degrees on all vent, enteral feeding or potential aspiration patients unless otherwise ordered and/or contraindicated. These patients who cannot tolerate HOB at 30 degrees will be placed at the maximum tolerated and interventions will be developed in attempt to increase tolerance.
5. If unable to turn themselves, patients will be turned every 2 hours, allowing for one three hour period of uninterrupted rest, if appropriate.
6. Assess need for OT/PT evaluation daily until patient is ambulatory.

Nutrition:

1. A dietary consult will be ordered for any patient that has identified needs as noted on the admission nutritional screen, has enteral nutrition, nutritional supplements ordered, or has identified medical conditions that increase their nutritional risk.
2. A bedside swallowing evaluation will be done on all patients after extubation prior to providing food or drink.
3. Obtain dietary consult for patients unable to tolerate meals (<30%) 24 hours post admission or post-op, NPO status greater than 48 hours, and patients determined to be at risk for malnutrition per Nutritional Screen.
4. Aspiration prevention: patients will be up in chair for meals or have HOB > 60 degrees. Chair or HOB will be maintained for 30 -45 minutes after meals, if possible.
5. Tube feeding residuals will be measured and recorded every four hours on the flowsheet (CLN policy -F003).

Documentation:

1. Any system that requires assessment more than every 4 hours will be documented under the complex assessment.
2. Pain, anxiety and other symptom assessment will be completed every four hours and PRN and interventions will be documented on the Vital Signs tab under pain assessment (policy P-002 Pain and Symptom). Specific medication administration will be documented on the MAR. (Using CPOT scale for pain, RASS Scale for anxiety and CAM assessment for delirium)
3. Frequent data entry items will be documented under the pain section. If there are no changes from the patient's prior assessment, the previous assessment may be copied over to that time's assessment.

Shift Duties:

All shifts:

1. Review and update Plan of Care/Education in EPIC with individualized activity, safety, mobility, comfort, education and other specific interventions and outcomes.
2. Facilitate ADL's and activity including up in chair and ambulation.
3. Review patient's progress with MD if available. Facilitate central line and Foley catheter removal. Assess transfer status and appropriate level of care.
4. Check for completed Admission Database, Advanced Directives, Immunization status and necessary CMS indicator documentation.
5. Assess for potential increase in diet and/or activity.
6. Monitor and decrease supplemental oxygen to minimal patient needs based on assessment, SPO2 readings or MD orders
7. Assess need for referrals such as care management, chaplain, PT/OT.
8. Keep patient's room clean.
9. Replace any 24- hour disposable items such as tube feeding bag and asepto.
10. Notify management of any elevated BNP, cardiac markers or diagnosis of stroke, and TPa administration
11. Clear pumps at 6 AM, 2PM and 10PM

Days:

1. Review morning lab results and initiate appropriate action if needed.
2. Apply TED hose

Nights:

1. Remove TED hose
2. Weigh patient
3. Bath vented patients whenever possible.
4. Change tube feeding bags and irrigation kit.

Patient/Family Education and support:

1. Provide emotional support. Refer to appropriate resources. i.e Pastoral care/Caring Bridge.
2. Education assessment needs will be documented under Education Assessment.
3. Education provided (using any and all teaching modalities available) and

patient/family response to education will be documented under assessment form, Plan of Care/Education.

4. Patient/family will have plan of care reviewed with them daily
5. Patient/family will receive orientation including an individualized explanation of all treatments and equipment including:
    a. Cardiac monitor
    b. Ventilator/oxygen therapy (i.e. pulse oximetry)
    c. IV therapy
    d. Nutritional support
    e. DVT prophylaxis
    f. Safety devices/restraints
    g. All medications including indications and side effects
6. Patient Lab Results and Testing Results Communication:
    a .Lab and/or testing results such as Cat Scans or Chest X-rays will be reviewed with the physician prior to discussing results with the patient and/or family.
    b. Upon physician approval the nurse may share results with planned physician follow-up.

Visitation:

1. Limitation of 2 individuals per room. This includes children.
2. Individuals must have vistor badge visible at all times.
3. Closure of unit from 7am – 9am and 7pm – 8:30pm to ensure patient confidentiality, safety during handoff.
4. No use of cell phones while on unit.
5. All patient families are requested to select one designated 'spokesperson' and password for communication to other family members and friends. Referral to Caring Bridge to facilitate communication if appropriate.
6. Visitation hours are patient dependent. Visitation will be decided by the nurse developing the plan of care and communicated with the family daily. Visitation is based upon:
    a. Patient condition
    b. Patient preference
    c. Ability to uphold the dignity and privacy of all patients
    d. Other ICU patient conditions
7. Only 'end of life' patients will be allowed more visitors based on nursing judgment and patient condition.
8. All children are to be supervised by an adult at all times.
9. Visitors feeling ill or running a fever are not permitted.
10. All visitors are expected to maintain a quiet and calm environment.
11. All Visitors are required to wash hands or use hand sanitizer upon arrival and leaving.
12. Visitors will be instructed on use of isolation barriers.

Discharge:

1. Verify that medication reconciliation, comparing home meds/current meds and discharge meds has been done by physician.

2. Validate that patient has been assessed and has received vaccinations when appropriate.
3. Assure completion and documentation of all patient discharge education and patient's response to learning has been completed.
4. All patients will receive a copy of their completed discharge instructions and appropriate explanation and instructions.
5. Patient belonging cabinets, bedside table and locked medication drawer will be emptied of all patient specific contents.
6. Notify management if blue, pink or yellow sheets are present prior to discharging the patient

GU:

1. Assess and document urine output at the same frequency and prn as vitals signs with patients with indwelling catheters.
2. Patients having difficulty urinating or suspected urinary tract retention will be assessed with the bladder scanner prior to considering in and out catheterization.
3. Catheters will be secured at the thigh and the location will be documented with the GU assessment.
4. Soap-and-water foley care will be done each shift and prn.

Basic Care:

1. Baths, oral care, linen changes (as needed) will be done a minimum of every 24 hours. Patient refusal must be documented. (Night shift should complete at least 1 bath on vented patients)
2. Oral care will be done a minimum of every 2 hours on all vented and NPO patients (unless NPO for procedure and actively sleeping).
3. Chlorahexidine will be used with oral care for vented patients every 12 hours unless not tolerated.
4. Patients with nasogastric tubes will have nasal care every 12 hours.
5. In conjunction with Respiratory Therapy, endoctracheal tubes will be retwilled and repositioned every 24 hours. If an ETAD device is used, the ETT will be repositioned every 2 hours by respiratory therapy or nursing unless not tolerated by the patient.
6. Incisional and drain dressings, including chest tube dressings will be changed every 24 hours and labeled with the date and time unless otherwise noted.

Safety/Restraints:

1. Morse fall scale will be assessed every shift and prn according to Clinical Practice Guidelines for Falls form in NPP section of INCOMM .
2. Purposeful rounding will be performed hourly on all patients and every 30 minutes if Morse scale > 75 in clinical Practice Guidelines for Fall section of INCOMM .
3. Vented patients will have side rails up x 4 when staff not in attendance.
4. For all other restraints refer to Restraints, Protective for protection from bodily injury NPP: CLN-2010, Protective Restraint Order and Restraint flowsheet document.
5. Bed alarm will be used for all patients with Morse scale > 75.
6. Utilize fall order sheet
7. Notify management immediately if a fall occurs and notify physician.

8. Gait belts will be used on all patients.

Head-to-Toe Assessment: Initial assessment is unique to the observer and the assessment parameters below are identified within EPIC. Any further assessment details not defined within EPIC should be made in the comment section or under Plan of Care in 'Notes'.

Neuro:
Further description of altered neuro presentation such as slurred speech, affect, sluggishness, somnolence, etc.
Reflect use of vent sedation. Continuous or intermittent administration.

Respiratory:
Ventilator settings.
ETT placement

Cardiovascular:
CV drug infusion.
Pulses presents and strength
Cardiac Rhythm

GI/Metabolic:
Tolerance of tube feedings.
Presence of TPN
Results of bedside swallow evaluation
Status of OG/NG

GU/Reproductive:
Bladder Scan results

Skin:
Changes

Musculoskeletal:
Tolerance of PT/OT

Fall Risk
Document purposeful rounding, bed position, side rail use, and use of bed alarm

Reviewed/ Revised by: ICU Evidence Based Practice Team and TICU Team. ICU Clinical Managers, and Theresa Murray MSN, CCRN, CNS

Approved by: Elsie Broda ICU Director

_____

Eleanore Wilson, Vice President of Nursing – CHN

_____

Bruce Ackerman ICU Medical Director

_____

Date: August 8, 2013

Community Health Network

STAFFING GUIDELINES for EMPLOYEES
COMMUNITY HOSPITAL NORTH
ICU, PCU and Med- Surg

I. Non Scheduled Occurrences – (Network Attendance Policy REF -000)

- Staff must call into work **AT LEAST** 2 ½ hours prior to scheduled shift start time. (i.e. 0430 a.m. for 0700 a.m. shift, 12:30 p.m. for 3:00 p.m. shift, 4:30 p.m. for 7:00 p.m. shift, and 8:30 p.m. for 11:00 p.m. shift).
- Not calling in by the 2½-hour time frame will be subject to corrective action.
- The expectation is all employees call in as soon as they are unable to work their shift.
- If calling in for a scheduled shift, PTO Eligible employees will have PTO-sick hours deducted from their available PTO balance for the missed scheduled hours.
- As business conditions warrant there may be instances when a leader may authorize a different shift to be worked to makeup the scheduled hours missed without having to use PTO Sick hours.
- A non scheduled absence occurrence is defined as an absence consisting of 2 hours or more in duration that is not pre- authorized or approved prior to the start of the shift (see Attendance Policy).
- Employees returning from an illness or injury in which 3 or more consecutive shifts are missed must be evaluated and cleared by Employee Occupational Health Services **prior** to returning to their work assignment.

II. Education

- Education time/workshops must be pre-approved by manager prior to schedule posting.
- When attending an authorized workshop or educational offering within the hospital (CHE, CHS, or CHN), it is important that accurate time records be maintained, therefore employees must clock in and out. Failure to clock in or out will result in inaccurate time records and may result in an incorrect pay check. Employee must contact nurse manager for any payroll errors, and the error must be logged and signed by the employee in order for the pay error to be corrected by the next payroll cycle.
- All authorized workshops or educational offerings must be written in the variance book in addition to clocking in and out.

III. Vacations / Time Off Requests

- Every consideration will be made to approve time off requests consistent with the patient safety and business requirements of the department.
- In submitting a time off request employees **must have enough PTO** to cover the duration of the request or the request will be denied.
- Vacations considerations will be made on a first-come first-serve basis. In the event that multiple staff request time off at the same time, for the same time or similar time period; and not all requests can be granted -unit tenure will be used to prioritize approvals.
- Specific dates must be submitted and **approved** before time off request is authorized. Please keep in mind that due to a limited number of staff being off at one time, **you must have approval prior to finalizing your plans.**
- Vacation requests for time off must be submitted to the appropriate nurse manager in charge of the schedule by the posted deadline date. All vacation and / or day off requests must be submitted by e mail or the "official form" – Department Leave Report.
- Vacations or time off request can only be submitted a maximum of six months in advance from the requested time off. If the time off request involves a special circumstance in excess of 6 months, the manager may use their discretion in considering.
- **It is the expectation that staff utilize PTO hours equivalent to FTE commitment.**
- PTO Eligible employees will have PTO hours deducted from their available PTO balance to meet their FTE commitment.
- If time off is requested after the schedule is posted, the employee is **expected** to find their own replacement, - i.e. trading a shift with another staff member:
    - Trade must be documented on the appropriate form.
    - Trade cannot create overtime.
    - Employee must meet FTE commitment.

IV. Holidays - (Holiday Pay and Holiday Premium Policy – Human Resources Policy 6C Holiday Policy – Human Resource Policy 11E)

- Staff will work pre-assigned holiday clusters and holiday clusters are rotated annually.
- Hospital recognized holidays are as follows:
  *Monday of Memorial Day
  *July 4th
  *Labor Day Monday
  *Thanksgiving Day
  *Christmas Day
  *New Years Day
- Staff is required to work a minimum of 24 hours of hospital recognized holiday time annually.
- Holiday commitment will take precedence over weekend time.

If a scheduled holiday falls on a weekend but it is not employees scheduled weekend, employee will be scheduled for that shift and vice versa if not employee's holiday

- No scheduled vacations during the week of Thanksgiving, the week of Christmas and the week of New Year's. Rare exceptions may be made depending on the individual situations.

- **Holiday shift call off will result in the following actions:**

  - Employee will be scheduled for next major holiday.
  - The same holiday that employee called off for the following year in addition to the employee's assigned clusters.
  - Absence will be unauthorized without pay.

V. Weekend Time is defined in the Weekend Premium Policy – Human Resources Policy 5C

- Weekend time
  - 0.1- 0.2 FTE staff will work 8 hour shift per six week schedule
  - 0.3 – 0.4 FTE staff will work 16 hours per six week schedule (ICU and PCU staff is required to work 12 hour shifts)
  - 0.5 – 1.0 FTE staff working 12-hour shifts: Every 3rd weekend 12-hour shifts (both weekend days together)-this is on a consistent every 3rd weekend rotation.
  - 0.5 – 1.0 FTE staff working 8-hour shifts will work every other weekend, both weekend days together.
- Employees working every 3rd weekend are allowed off 3 scheduled weekends per year. Employees requesting additional weekend time off must work another weekend at managerial discretion
- Employees working every other weekend are allowed off 4 scheduled weekends per year. Employees requesting additional weekend time off must work another weekend at managerial discretion

VI. PRN

a. See PRN agreement

VII. On-Call / C-Time Standby - Stipend/ Call – Pay Human Resource Policy 4C

b. On-call and C-time will be distributed on a rotating basis at managerial discretion

- On-call and C-time is required when it is determined to be your turn and refusing to be on-call/ take C-time can be subject to corrective action.
- Decision Tree: 1st Over-time
  2nd Resource Team
  3rd Employee requests signed up in advance
  4th PRN

5th over FTE
6th Regular staff
This is only a guideline and managerial discretion applies. (C-time Policy)

- If on-call:
  - **Employee must be available to report to work within an hour – (shower, dress and drive time included)**
  - Employee is expected not cancel your sitter, do not babysit, if you leave the house take your scrubs and cell phone w/ you.
  - Employee must be able to be reached by phone at all times. (this may include providing an alternative phone number to the staffing person.)
  - (12 hr shifts) You are placed on-call for the first portion of your 12 hour shift, if you are not called a second time and placed on-call again; you are expected to come in at the start of the next 8 hr shift. (12 hr shift- 7a – 7:30p: on-call 7a – 3p and expected to come in at 3pm for last portion of your shift) (12 hour shift 7p – 7:30a: on call 7p – 11p and expected to come in at 11p)
  - Employee is expected to come in up until 2 hours prior to the end of your shift.

VIII. Miscellaneous

- A "No Call" "No Show" absence event will be subject to corrective action.
- Special Cause Circumstances – If you anticipate or experience a time off related event that falls outside the norms of a scheduled time off request, please contact your department leader as soon as possible. If your situation is viewed as a special cause event, every consideration will be made to try and accommodate the need. Failing to be timely or pro-active in such a request reduces the likelihood that consideration will be given to such a request.
- Once the schedule is posted, staff cannot cancel themselves for a scheduled shift. Canceling of a shift after scheduled/ signing-up will count as an occurrence.
- Any staff member leaving the premises (Community North Hospital) must obtain approval from Nurse Manager or designee prior to leaving or may be subject to corrective action. If a staff member leaves the building, they must clock out and then clock back in upon their return.
- Employees are not to clock in prior to 7 minutes before the start of their shift unless authorized by their manager or director. The first occurrence will be a "verbal" warning. The second occurrence will be a "written" warning. The third occurrence will result in a corrective action. (See HR Corrective Action Policy). The "7 minute" rule does not apply if a Manager or designee has asked an employee to clock in early due to the business needs of the unit.
- Employee is expected to provide a resignation period of notice of no less than two calendar weeks (14 days) or their termination paperwork will reflect that this expectation was not met, and will be denoted in the termination paperwork.(Resignation Policy– Human Resources Policy 1G)
- Staff may not decrease FTE status between October 1st of current year and January 3rd of next calendar year. The FTE change if approved will become effective with the next schedule. If request is made less than two weeks before posting of next

schedule, the FTE change (subject to approval) will occur at the next available opportunity.

- Expiration of any required Licensure, Certification, or Mandatory requirement defined by law, regulation, policy or role summary will result in a corrective action and the employee will be removed from the schedule without pay until compliant. This includes (CPR, TB, NRCP…).
- **Employees may be allotted a 30 minute meal break subject to patient safety and the business conditions of unit.** Any additional breaks are a privilege and will be based on patient safety and business conditions of the unit.
- Handoff Communication
  - Licensed Staff
    - Employees must hand off to another licensed employee anytime they are leaving the unit and a hand off must include the 6 C's of Communication. (See Handoff Communication – CLN policy 3025)
  - Non Licensed Staff
    - Employees must communicate with RN and secure approval prior to leaving unit

I have read and understand the ICU/PCU/Med-Surg Scheduling Guidelines.

Employee Signature: _____

Printed Name: _____

Date_____

COMMUNITY HOSPITAL NORTH
INTENSIVE CARE
EMERGENCY OPERATIONS PLAN

The ICU recognizes its responsibilities in planning for emergencies/disasters by applying the four phases of emergency preparedness.

I. MITIGATION: Any action taken to eliminate or reduce the degree of long-term risk to human life and property from any type of hazard.

A. *Departmental mitigation efforts include:*

1. Four extra flashlights, eight "D" size batteries, and bag for chart storage are stored in the nursing station behind the secretary's desk.

2. Two boxes of gloves are in each room. Additional boxes are in the storage room in the hall across from 2712.

3. Sprinkler system is in place in the ICU.

4. One Ambu bag is in each room. Extra Ambu bags are kept in the respiratory par level across from 2724 and ICU par level across from 2712.

5. There is one regulator with four oxygen tanks in the storage room across from 2712 and 2724.

6. One Helium tank is in the storage room across from 2724.

7. Four oxygen extension tubing sets are in the cabinet behind the secretary's desk. Additional extensions are in the Respiratory Par Level across from 2724.

8. Two isolation kits which include blood pressure cuff, penlight, and stethoscope are kept in the storage room.

9. Material Safety Data Sheets (MSDS) are located in the notebook in each of the ICU nursing stations on the policy/procedure shelves.

10. Fire extinguishers are located in the following places:

    a) *Hallway between staff lounge and rest room*

    b) *27A (Rooms 2701 – 2712) - main nurses station*

    c) *27B (Rooms 2113 – 2724) - main nurses station*

d) *Across from Room 2724*

11. Oxygen shutoff valves are located:

    a) *27A (Rooms 2701 – 2712) - main nurses station*

    b) *27B (Rooms 2113 – 2724) - main nurses station*

12. Pull down fire alarms are located:

    a) *27B (by room 2724) entrance - left side after double door entrance*

    b) *Wall by doctor's dictation area*

    c) *By door to stairwell (by room 2713)*

    d) *27 A (rooms 2701 – 2712) - on wall between nurses station and medicine prep room*

13. Red outlets are located in the below areas:

    a) *20 on column in each patient room*

    b) *1 in each alcove for Crash Carts*

    c) *8 in each main nurses station*

    d) *4 in medicine prep rooms where Pyxis is plugged in*

II. PREPAREDNESS: Any activity taken in advance of an emergency that facilitates the implementation of a coordinated response.

A. *Departmental preparedness efforts include:*

1. Completion of Departmental Emergency Operations Plan (EOP). It is reviewed every three months for changes/updates of equipment and personnel.

2. EOP is located in the red Disaster Manual located in 27 A and 27B nursing stations on shelves with nursing policy/procedure

books. The Director, Clinical Managers, and Administrative Assistant each have one copy.

3. Fire extinguishers are checked by Security monthly.

4. All supplies are checked and/or replaced on the first of each month by a Patient Support Partner. They will initial the checklist which will be placed with the EOP, i.e. flashlights, batteries, gloves, oxygen tubing, etc.

5. Provide orientation to all staff of emergency/disaster procedures when hired and then yearly.

6. Annual Fire and Safety education emphasizing RACE (Rescue, Alarm, Contain, Extinguish) and PASS (Pull, Aim, Squeeze, Sweep) utilizing a computer assisted instruction course.

7. Staff will participate in mock disasters twice per year.

8. Staff will participate in mock fire drills when Security makes spot checks.

9. Staff is in-serviced yearly in Hazardous Communication and Lock Out/Tag Out.

10. Update department employee roster with telephone numbers and time to arrive at CHN, including special skills every three months.

11. One hundred percent (100%) of the Care Managers are ACLS prepared based on ICU professional goal process.

12. Emergency telephone is available in both ICU nursing stations.

13. Pay telephone located across from the Surgery Waiting Room.

14. Each staff nurse has a key to the medication drawers in the patient rooms and in the medication rooms.

15. Crash Carts are located in alcoves across from 2704 and 2721.

16. Copier/Scanner is across from the Physician Dictation area.

17. Television with VCR/DVD player is kept in ICU Conference Room

18. Overhead Projector in ICU Conference Room.

19. There is a microwave oven in both patient kitchens and staff lounge.

20. Refrigerators are in both kitchens, and one is in the staff lounge. A small locked refrigerator is in both medication rooms for medications only.

III. RESPONSE: Any action taken immediately before, during, or directly after an emergency occurs to save lives, minimize damage to property, and enhance the effectiveness of recovery.

A. *Departmental response efforts include:*

1. Removing patients/visitors, etc., from window areas.

2. Close all doors unless chance of glass breaking, then move patient's bed close to counter behind column and pull bedside commode curtain around them and then put a blanket over them. Leave break-away door open and close room curtain.

3. Closing all blinds and curtains.

4. Staff notified via overhead paging system of type of emergency.

5. Care Manager, Clinical Partner, Administrative Support Partner, Student Nurse Extern, or Patient Support Partner can activate call-in procedure of staff from home to provide nursing support within the hospital.

6. Director and Clinical Managers, and/or Bed Placement Staffers will be notified if not in hospital. Individual that has initiated the call-in will call the Director, and Clinical Managers, and/or Bed Placement Staffing.

7. During an emergency, staff will work no more than 16 hours at a time. They will sleep in the Intensive Care Conference Room, staff lounge, and any other designated area.

8. Evacuation of patients/visitors, etc., from the hospital.

9. Immediate care to any injured staff, patients/visitors, etc.

10. Assisting other departments as needed.

IV. RECOVERY: Any short term activity to return vital life support systems to minimum operating standards; and long-term activity designed to return the hospital/department to safe and normal levels of activity.

A. Departmental recovery efforts include:

1. Department assesses equipment for damage.

2. Electrical equipment that is subjected to water must be checked prior to use.

3. Damaged equipment returned to CSR for exchange.

4. Computers and printers should be checked if dropped.

5. Staff will maintain normal functioning in rooms that are not damaged on the ICU.

6. Return patients to unit/rooms, if possible.

7. Notify Environmental Services to assist with debris removal.

8. Computer software is on the Local Area Network (LAN).

9. Reports are on the LAN that is backed up nightly. If paper copies are destroyed, they will still be able to be reproduced.

10. Staffing assignments for the day are written on the dry erase board across from the physician dictation area and in appropriate nursing station and on the weekly sheets that are in the staffing book.

11. Old weekly staffing sheets are kept in the Clinical Manager's office. If current sheets were destroyed, staff would be able to reproduce them sufficiently.

12. Pharmacy keeps faxed physician orders for one month. If patients are still hospitalized, Pharmacy can retrieve all medication orders from these sheets, or they are able to pull up computerized medication records on all patients.

13. If charts are destroyed, the patient's physician and Care Manager can write a summary of the patient's hospital stay. If able, Administrative Support Partner will put all patients' charts in a bag supplied in the emergency cabinet.

14. There are ten telephone lines in the nursing station, one in the lounge, four lines in the doctor's dictating area, six in the Clinical Manager offices, and two in the ICU Conference Room.

15. If the G E. (Marquette) slave monitors, bedside monitors, central monitoring station, and full disclosure were to go out, we would need to call Clinical Engineering first at 355-5017. They would call G. E. if they could not repair them. If all telemetry was destroyed, eight monitors in the central monitoring station will need to be replaced (Solar 8000M - 2 monitors and - 4 monitors); two full disclosure monitor (Solar 8000M), two LaserJet 4 printers, and two LaserJet IIP printers; 24 bedside monitors (Solar 8000M monitors) 2 monitor printers.

16. If the power would go off, the emergency power would supply some lights throughout the unit, the exit signs would be on, and emergency power would insure that the negative airflow was working in Rooms 2712, 2713, 2719, and 2720.

17. Maintenance would be called to check negative airflow in Rooms 2712, 2713, 2719, and 2720.

18. If we were not able to flush the toilets, patients and staff would utilize bedside commodes. To decrease the smell and bacteria, Environmental Services would supply the unit with unscented bleach.

19. ICU Equipment:

    a) *2-Crash Carts*

    b) *2-Medtronic Pacemakers (Model #5375 & #5342)*

c) 2-Camino V420-6 ICP Monitor (Serial # 63924 and 63925)

d) 3 - GE Transport Monitor (Transport Pro)

e) 1 Edwards Life Sciences Vigileo Monitor (Asset tag # 64297)

f) 1- Edwards Life Sciences Vigilence SV02/CCO Monitor

g) 24-EKG Modules and (24) EKG Cables

h) 24-NBP Modules and (24) NBP Cables

i) 24-Pressure Modules and (24) Pressure Cables

j) 24-Cardiac Output Modules and (24) Cables

k) 3 BIS monitors and cables

l) 1 Sonasite Doppler Machine (serial # 030LRR)

m) 1 Sonasite Doppler Machine (serial #03TPZB and power source with Community tag #68094.

n) 3 Esophageal Doppler Monitors (2 with stand and 1 without stand)

o) 1 flexible fiberoptic scope for difficult intubation (maintained by respiratory therapy)

p) 14 Galileo Ventilators (maintained by respiratory therapy) Serial numbers maintained by Clinical Engineering

q) 2 – 7200 Ventilators (maintained by respiratory therapy) Serial numbers maintained by Clinical Engineering

r) 4 Ream Star CPAP Machines (maintained by respiratory therapy)Serial numbers maintained by Clinical Engineering

s) 6 Vision BiPap Machines (maintained by respiratory therapy)Serial numbers maintained by Clinical

Engineering

t) 1 transport Ventilator

u) Responic Ventilators

v) 2 C2 Ventilators (maintained by respiratory therapy)
Serial numbers maintained by Clinical Engineering

w) 36 Oxygen Flow Meters

x) 24 Air flow Meters

y) 48 Suction Heads

z) 14- Levels

aa) 10-Tycos

bb) 20 - Pressure Monitoring Blocks

cc) Dukane Pro Care 4000 Plus Call Systems

dd) 2-SharpCopier/ Fax Machines (nursing stations)

ee) 7 in 27A and 5 in 27B - personal computers with large screens (nursing stations)

ff) 4 - personal computers with large screens (nursing sub-Stations)

gg) 5 - personal computers (doctor's dictation room)

hh) 24 - personal computers with large screens (patient rooms)

ii) 24 medication Barcode Scanners

jj) 5 - personal computers (ICU Nurse Manager and PCC's)

kk) 3 personal computers for ECCO

ll) 2-HP LaserJet 4050T Printers (nursing stations)

mm)- Sharp Printer (Doctor Dictation Area)

nn) 1-Toshiba Television (ICU Conference Room)

oo)1-RCA Television (staff lounge)

pp) 21-chairs in conference room

qq) 7-conference room tables

rr) 24-Televisions (patient rooms)

ss) 48-chairs for patient rooms

tt) 3-cardiac chairs

uu) 1 blue bari chair

vv) 1 hydraulic bari chair

ww) 2-sleeper chairs (ICU waiting room)

xx) 4- Stryker med – surg beds

yy) 21-Stryker I Touch Series

zz) 3 – Zoll (model M) defibrillator/pacing monitors

aaa) 2-Armstrong Medical A-Smart Code Carts

bbb) 22 - IVAC thermometers

ccc) 3 "9" volt batteries for temporary pacemakers

ddd) 1 box each of AA and AAA batteries

eee)2 Sonasite Ultrasound Doppler and stand

fff) 5 chair check monitors

ggg) Bladder Scanner (Diagnostic)

hhh) 2 Peripheral Nerve Stimulator (Neuro technology and Fisher Paykel)

iii) Blanket Warmer (Augustine Medical)

jjj) I vein light

kkk) 2 3M Surgical Clipper and Charger

20. The unit would need 7,500 gallons of water for 72 hours

21. The unit would need the following books replaced:

a) Physicians Desk Reference (PDR)

b) ICU Charge Nurse Book

c) Oncology Resource Manual

d) IV Resource Book

e) IV Compatibility Book

f) Material Safety Data Sheets (MSDS)

g) Nursing Drug Reference

h) Critical Care Reference Books

i)Patient Rights Handbook

j) Human Resources Policies & Procedures

k) Nursing Policies & Procedures

n) Professional Practice Manual

l) Disaster Manual

m) Safety Manual

n)Infection Control Manual

o) Corporate Standard Policies & Procedures Manual (SPP)

DEPARTMENTAL ROLE IN EMERGENCY/DISASTER SITUATION:

The role of the ICU in an emergency/disaster situation will be similar to those duties performed in day-to-day operations.

In the event the Emergency Operations Plan is activated, the line of succession and chain of command for department administration is:

i. Director

ii. Nurse Manager

iii. Patient Care Coordinator or ICU Charge nurse on day/evening/night shift

1. Any individual assuming department command has full authority to commit departmental resource in responding to the emergency/disaster situation.

2. Other Directors will act in an advisory capacity to the department commander and will assume the role if an emergency warrants and as needed.

IV. Specific roles the ICU will assume during an emergency/disaster include:

1. Institute call-in for off duty staff including Care Managers, Clinical Partners, Patient Support Partners, Student Nurse Externs, and Administrative Support Partners.

2. Assist other departments, as needed, in caring for those critically injured, i.e. Emergency Department.

3. Provide as much information to family members/visitors as possible.

Community Hospital North

Indianapolis, Indiana

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

SECTION 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."

NARRATIVE RESPONSE AND DISCUSSION

Section 15 includes signed letters of commitment from our Laboratory Medical Director and our Laboratory Manager affirming compliance with all standards set forth by the American College of Surgeons. Also included are Community North policies including "Blood Component Administration", "Critical Blood Supply Policy", and "Emergency Release of Blood Components. There is also a copy of the contract with Indiana Blood Center for Community North included. A committee is currently meeting to develop a Massive Transfusion Policy that would be applicable to Trauma patients. The Performance Improvement and Patient Safety will continuously monitor and re-evaluate all cases to ensure that we are meeting standards of blood administration.

Community
Health Network

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 North in the 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 North. 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), cryoprecipitate, and other proper clotting factors. We have a contract with the Indiana Blood Center to have platelets, and a wide variety of other blood products delivered to Community Hospital North when needed twenty-four hours per day. These are typically available to administer within 30 minutes to one hour.

Respectfully,

Norman Hurwitz, M.D.
Laboratory Medical Director

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community
Health Network

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 Manager. I am pleased to support Community Hospital North'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.

I further understand that my role is to ensure that blood bank services are available twenty-four hours per day at Community Hospital North. We have a contract with the Indiana Blood Center to have platelets, cryoprecipitate, and a wide variety of other blood products delivered to Community Hospital North when needed twenty four hours per day.

Respectfully,

Kathy Braniff, MLS(ASCP)
Laboratory Manager

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community Health Network

CORPORATE NURSING POLICY AND PROCEDURE NPP#: I-14B1
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH Page 1 of 12
CANCELS: 5/21/13emergent EFFECTIVE: 8/8/13

TITLE: **Blood Component Administration**

Performed by:

1. Obtain blood components from Blood Bank: RN, LPN, MHC, PSP, PST, AP, SE, EMT-P (competency verified). Nursing may request Security to obtain blood component from Blood Bank.
2. Start Infusion and administer blood products: RN, LPN, NP, CNS

Purpose: To provide guidelines for administering blood components.

Policy Statements:

1. A patient must be identified prior to the administration of any blood product according to **CLN 3017, Identification of Patient, Use of Two Patient Identifiers**. If the patient is able to communicate, ask the patient to state their name and birthdate. Additionally, verification of patient identification will occur by comparison of patient name, birthdate and medical record number on the blood product slip and the EMR to the patient name, birthdate, and medical record number on the patient's armband. If the patient is unable to communicate, nursing will compare the EMR, patient's armband, and blood product information and verify that all are accurate. All information will be an identical match to patient EMR, armband and blood product. If any information is not correct the blood product must be returned immediately to the blood bank.
2. A physician order is required to administer blood components. Blood Consent/Refusal form must be completed for all blood component transfusions, which includes: Red Blood Cells, Plasma, Cryoprecipitate and Platelets. The form should be signed before obtaining the Type and Crossmatch (T&C) or Type and Screen (T&S) blood sample, but must be signed before the blood component is administered. **(Exception: Physician order to administer blood without the patient's consent in an emergency situation. If blood is administered in an emergency without consent, the reason must be documented in the patient's medical record.)** The consent remains in effect during the hospitalization and a new consent is required for each new inpatient admission. A new consent is required when a patient is admitted to or from Behavioral Health or Rehabilitation Hospital or from an outpatient to an inpatient status.
3. IgG or Rh Immune Globulin are not blood components and do not require signed consents before administration.
4. A red Blood Bank Armband (Blood Recipient ID Band) will be placed on all patients who have a T&S/T&C drawn in an outpatient area/Emergency Department, or on all patients who do not have a Medical Record number. The armband must remain on the patient until midnight of the third day after the T&C/T&S specimen was drawn. If present, this armband must be used as a method of identification. If removed during this period, a new T&S/T&C must be ordered and a specimen drawn.
5. Do not obtain blood products from the Blood Bank until a working patient IV is established. (Exception: Emergency Situations.) The physician's order or the RN's judgment regarding the condition of the patient will be used to determine whether or not to interrupt an already existing IV infusion or to start a second IV site to administer the transfusion. If infusing parenteral nutrition, ($D_{10}W$ concentration or greater and/or lipids), or a continuous PCA narcotic, a second IV site must be started. If unable to obtain a second IV site receive orders from physician for possible interruption of other therapies that cannot be given during blood component infusion.
6. If the patient has an arteriovenous (AV) graft or fistula, blood may not be infused through the graft or fistula unless it is during dialysis.
7. A computer generated requisition to obtain blood label with the patient name (first and last), medical record number, and DOB must be presented when picking blood components up from the Blood Bank. Exception: A handwritten label with the patient's first and last name, Medical Record

Number, and DOB may be used if the patient's condition warrants emergency blood administration and a computer label is not readily available. The person picking up the blood component from the Blood Bank (known as the transporter) must be aware which blood component is to be obtained if the patient has multiple blood components ordered. Blood bank personnel are to be informed by transporter which product component is needed. NOTE: If patient has a red armband, the sticker from the red armband must accompany the label with patient's name, DOB and medical record number in order to pick up the blood.

8. Uncrossmatched red blood cells will be given in an emergency situation when a T&C/T&S specimen has not yet been obtained, but T&C must be obtained as soon as possible and sent to Blood Bank. See NPP#I-14,B-2, Blood, Uncrossmatched for additional information.
9. Blood tubing must not hang for greater than four hours. If more than one blood component is infused, the blood tubing must be changed if the infusions are not completed within the four hour time period. No more than four red cell products can be infused through the same blood tubing.
10. **All blood components must be started and be completely infused within four hours from the time the units leave the blood bank.**
11. **If it is necessary to infuse longer than this, prior arrangements must be made with Blood Bank.** Blood Bank will arrange smaller volumes ("aloquets")to infuse if necessary; for example, Pediatric patient or patients with CHF.
12. If the blood component cannot be started upon arrival to the unit it must be returned to Blood Bank as soon as possible to avoid wasting it..
13. Multiple blood components <u>on a single patient</u> can be released to a nursing unit if the patient's condition warrants. Under no circumstances is blood to be stored in a refrigerator on the nursing units. **Coolers will be provided to nursing by the Blood Bank for the storage of multiple units in surgery, critical care areas, ED or transfusions taking place at areas remote to the blood bank. These coolers are for the use of red cells and plasma products. Platelets and cryoprecipitate are stored at room temperature. The coolers are labeled with information stating when the ice in the cooler must be replaced or returned to the blood bank.**
14. For the pediatric patients less than 100 pounds, the physician must order the amount and rate of blood administration. If this is not specifically ordered, the physician must be contacted.
15. Nursing will monitor the patient in the following ways, pre-, during, and post-transfusion:
    a. By checking the specific physician order for accuracy of blood component to be administered before hanging the component.
    b. By obtaining and recording the temperature, pulse and respirations (T-P-R) and blood pressure (B/P) before the start time of the transfusion and the second set of vital signs between the first 10 and 20 minutes of the infusion.
    c. By obtaining patient temperature a minimum of every 30 minutes during the transfusion when clinically indicated for signs and symptoms of a possible reaction.
    d. By obtaining T-P-R and B/P within 15 minutes of completion of transfusion.
    NOTE: If a transfusion takes less than 15 minutes to complete, the 15 minute assessment and the completion assessment may be completed and documented at the same time, the vital signs would be completed in the post transfusion section and the pre transfusion section for the next unit.
16. During the transfusion of all blood components products or upon its completion, if the patient experiences a 2^0F increase or more (one degree Celsius) in temperature, or any other sign/symptom of a transfusion reaction, the transfusion is to be stopped. Call the Blood Bank immediately, receive instructions for transfusion reaction work-up and notify physician. The Blood Bank will inform the nurse of the necessary items for a Transfusion Reaction Work-Up. (These include: post transfusion blood bank specimen correctly labeled, yellow copy of the transfusion record form with reaction information completely filled out, all tubing, filters, fluids and blood components used in the transfusion, and the Transfusion Reaction work up order

requisition.) Orders received from the physician and rationale for interventions must be documented.

17. **In the event that the patient dies while receiving a transfusion,** perform the following: **document on the transfusion record form that patient died, contact blood bank, send all paper work and tubing to the blood bank, and if possible obtain a post transfusion specimen.**
18. No medication is to be added to or administered with blood components. Use only normal saline (0.9% saline) with blood components.
19. All crossmatched blood and T&C/T&S orders will be automatically released at midnight of the 3rd day from when the specimen is collected. Should the patient require blood after this time period, a new order and crossmatched specimen must be obtained. EXCEPTIONS include pre-op T&C and Pre-op T&S which may be extended for 30 days with pre-op questionnaire.
20. A patient refusing to receive blood for religious or other reasons must sign the Blood Consent/Refusal form section. See Corporate Policy CLN:2062, "Blood Transfusions, Refusal Considerations".
21. Patients requiring transportation while receiving a transfusion must have an RN, Perfusionist or physician in attendance. Hand off to the unit of destination must be to an RN, Perfusionist or physician.

General Information:

1. Potential signs and symptoms of a transfusion reaction include: chest pain, back pain, itching, rash, hives, shortness of breath, feeling anxious, increase in temperature greater than or equal to 2 degrees Fahrenheit or 1 degree Celsius from pre-transfusion baseline vital signs or anything out of the ordinary.
2. Patient identification consists of inspection of the identification armband to verify that the name, date of birth and medical record number are the same as on the Transfusion Record Form and the blood component unit label. If a red Blood Bank Armband (Blood Recipient ID Band) present, this armband must be used as a method of identification.
3. Unit(s) identification consists of verification from the blood component unit label, including:
   a. Patient's Name
   b. Medical Record Number or identification number on red blood bank armband(Blood Recipient Identification Band)
   c. Date of Birth (DOB)
   d. Donor number
   e. Blood Type of unit
   f. Blood type of patient
   g. Unit Expiration
   h. Other specifics, for example, irradiated, CMV.
4. T&C/T&S at CHVH, CHN, CHE, or CHS and processed by Mid America Clinical Laboratories is valid for use at all sites listed above. Any patient transferring from any other location needs need a new T&C and T&S drawn.
5. A physician, NP, CNS or Perfusionist may start infusion and administer blood products.
6. It is recommended that intravenous catheter sizes for use in transfusing cellular products, (Red cells and platelets), range from 14 to 22 gauges.
7. All Red Blood Cells received from Indiana Blood Center are Leukoreduced.

Equipment:

1. IV Pole
2. Blood Administration set
   a. Double Y- type blood tubing (Whole Blood, Packed Cells, and FFP, Platelets, Leukocytes, and Cryoprecipitate)

b. 30ml syringe with filter needle (Factor VIII/Factor IX)
3. Blood warmer (optional) is ordered by physician. (Instruction sheet on machine.)
4. Infusion pump if blood component is to be infused through a central line. An infusion pump is optional if a blood component is infused peripherally.
5. 250 ml Normal Saline (0.9% saline)

A. Obtaining T&C or T&S (Type and Cross/ Type and Screen):

1. If T&C or T&S is needed, identify the patient using the two patient identifiers as described in CLN 3017, Identification of Patient, Using two patient identifiers.
2. Obtain specimen by drawing blood in Blood Bank designated vacutainer tube.
3. On the vacutainer pre-affixed label and print **in indelible ink** the following information:
   a. Patient's full name
   b. Patient Date of Birth
   c. Medical Record number
   d. Date, time and phlebotomist's initials
4. Complete collection information on the lab requisition to include:
   a. Date/time of collection
   b. Phlebotomist's initials
   c. Notation that hospital or red blood bank arm band is present when specimen was drawn.
   d. One additional patient identification item listed below
      1.) Patient said name was:_____
      2.) DOB
      3.) Staff identification of patient
5. Place a red blood bank armband (Blood recipient Identification Band) on patients who have had T&C/T&S drawn in outpatient areas or before a Medical Record number is available. Affix the patient ID portion of this armband on to the tube of blood in the presence of the patient.
6. Place specimen, strip of armband numbers if using Identification Band and requisition in plastic bag and deliver to Blood Bank. Blood Bank refuses specimen if:
   a. There is incomplete labeling of specimen including misspelling of any portion of the name, missing medical record numbers including zeros and omission of date/time of collection and phlebotomist's initials.
   b. There is inaccurate labeling of specimen which includes using printed labels for T&C and T&S.
   c. Specimen labeling is not in agreement with requisition.

B.Obtaining Blood Component(s) from the Blood Bank

1. The transporter hands the pick-up slip to the Blood Bank associate at Blood Bank If the patient has a red armband, the sticker from the red armband accompanies the label with patient's name, DOB, and medical record number in order to pick up the blood.
2. The Blood Bank associate retrieves the blood component(s) and dispenses in the laboratory computer.
3. The transporter then reads to the Blood Bank associate the following from the Transfusion Record Form:
   a. Patient Name
   b. Medical Record Number
   c. Date of Birth
   d. Patient ABO/Rh
   e. Unit ABO/Rh
   f. Unit number and correlating red armband number if appropriate
   g. Component
   h. Crossmatch results

i. Unit expiration date and time
j. Comment

4. The transporter then signs the Transfusion Record Form (s) in the area **TRANSPORTED BY** along with the date and time, and the department where the transfusion will take place.
5. The transporter hands the Transfusion Record Form (s) back to the Blood Bank associate to sign in the area marked Technician Issuer
6. The Blood Bank associate removes the pink copy from the Transfusion Record Form (s) and places the Transfusion Record Form, Blood Bag label and blood component in a bag (either paper or plastic) or cooler for transportation to the nursing unit.
7. The Blood Bank associate dates and writes the 4 hour blood product outdate time on the Blood Bag Label sheet and includes this in the bag or cooler for transportation to the nursing unit.
8. Pneumatic Tubing of Blood and Blood Products for NICU and CHVH (weekends only for CHVH):Complete the Blood Pneumatic Tube Transport form (see addendum # 3).
   a. Perform 2 patient Identifiers with physician order before sending form to Blood Bank
   b. If patient has a blood bank band include the number in the space provided on form
   c. Handwrite the patient's full name and birthdate, Medical Number, and Room number
   d. Fill in number of Product Requested :_____
   e. Quanity:_____ Tube Station:_____
   f. Phone:_____Initials:_____
   g. Follow the instructions to "Send request form via pneumatic tube"

2. Blood Bank :
   a. Completes the "Date/Time Product Sent" section of the Blood Pneumatic Tube Transport form and they will retain the bottom (yellow) copy
   b. Notifies the Clinical area that the blood product is being sent.
   c. Places product, Blood bag label dated with the 4 hour blood product outdate time and top copy of transport form in sealed Ziploc bag(s). Place
   d. Ziploc bag into a pneumatic tube.
   e. Blood bank tech calls receiving area if "Blood Pneumatic Tube Transport" form is not returned to the Blood Bank within 15 minutes.

3. Clinical area removes unit from the pneumatic tube system and
   a. compares the information on Unit Compatibility label, Transfusion Record Form and Blood Product Request Form.
   b. Complete the "Receipt" section of the Blood Pneumatic Tube Transport form
   c. Returns the form and the refrigerated gel pack (if applicable), via the tube system to the blood bank.
   d. Two members of the transfusing staff verifies donor unit information per Blood Administration policy, with the transfusion tag and patient wristband information at the patient's bedside.
   e. If there are any discrepancies, the Neonatal Intensive Care Unit (NICU) personnel will **WALK** the unit back to the Blood Bank for resolution. For discrepancies at The Indiana Heart Hospital (CHVH) the staff call the Blood Bank for further instructions.

C. Transfusion

1. Complete bedside verification process using the Transfusion Record Form. Utilizing two 2 staff members, one of which is a licensed professional (RN, LPN, Physician/NP, Perfusionist).Compare -the specific physician order for accuracy of blood component to be administered before hanging the component. Scans the blood bag for the unit number and the product code number.
2. Compare the patient's name, DOB, and medical record number on the identification armband with the patient's name, DOB and medical record number, and if applicable the red armband number on the Transfusion Record Form and the blood component unit label.

3. Compare the unit number, ABO group, and Rh on the blood component unit label with the unit number ABO group, and Rh on the Transfusion Record Form. Contact Blood Bank immediately for any discrepancies.
4. Obtain baseline Respirations, Pulse, Temperature and B/P immediately prior to transfusion. If patient's temperature is 101^{0}F or above, notify the physician prior to starting the blood component and receive orders.
5. Attach blood component to prepared IV tubing.
   Infuse at:

Component	1st 15 minutes	After 15 minutes	Pediatric
Red Blood Cells	75 ml/hour	150 ml/hr	2-5mL/kg/hr
Plasma	NA	200-300ml/hr	60-120 mL/hr
Platelets	30ml/hr	200-300mL/hr	60-120mL/hr
Cryoprecipitated AHF	As Rapidly as Tolerated		As Rapidly as tolerated

6. The RN observes the patient closely, assessing and monitoring the patient for the first 15 minutes after the transfusion is started to observe for potential signs and symptoms of a transfusion reaction.
7. Between the first 10 and 20 minutes of the infusion, obtain vital signs including temperature, pulse, respiratory rate, and blood pressure and document the complete vital signs on the Transfusion Record Form. Observe the patient for shaking, chills, pain, nausea, itching or other symptoms and document. If the patient's condition is satisfactory, the rate can be increased to that listed in the table above.
8. Continue to monitor and assess the patient intermittently throughout the transfusion.
9. If a unit of blood has been infusing for more than 4 hours, discard remaining blood in red biohazard containers in dirty utility area and completely change all IV tubing that was used for transfusion.

D. Post Transfusion:

1. After transfusion is complete, flush blood tubing with normal saline, then discard all blood tubing, bag and supplies from transfusion in red biohazard container in dirty utility area.
2. Resume previous IV fluids. If IV site may be needed for additional transfusions, then maintain as a PIV lock.
3. Take post-transfusion vital signs (T-P-R & BP) within 15 minutes of completion of the transfusion and record on the Transfusion Record Form.
4. Review and verify Transfusion Record Form is complete with all appropriate signatures, dates and times. Unlicensed personnel may collect vital sign data; however, all vital signs must be reviewed and initialed by the RN. Place original in chart and send yellow copy to Blood Bank via pneumatic tube . If no access to pneumatic tube send via interdepartmental mail .

E. Transfusion Reaction

1. Stop the transfusion immediately if any symptoms of a reaction occur. Immediately switch from blood infusion to saline and get specific treatment orders for reaction from physician. Mild urticaria, hives, or an increased of temperature less than 2^{0}F (or 1^{0}C) alone may not be deemed a sufficient indication by the physician to discontinue the transfusion. All other symptoms require the stopping of the transfusion and proceeding with steps 2, 3 ,4 and 5.
2. Immediately, visually check the patient armband, blood product unit label and transfusion record form, to verify that this is right patient, right blood product, right patient medical record number, and that all information matches the patient arm band, blood component unit label and the Transfusion Record Form.
3. Call the Blood Bank for instructions on proceeding with a transfusion reaction work-up.

4. Order a transfusion reaction work up. Complete and sign the Transfusion Record Form and return yellow copy of the Transfusion Record Form and the blood component bag with all blood tubing, tags and fluids to the blood bank (place in biohazard bag for transport from patient unit to the blood bank.) Transfusion Reaction Record is completed by the Blood Bank. Nursing to document in the EMR.
5. For general information regarding specific transfusion reaction, see addendum. There is the possibility of delayed hemolytic reaction. This type of reaction most frequently occurs between 3-14 days post-transfusion.
   a. **Transfusion Associated Circulatory Overload (TACO)**
      Definition: Infusion volume that cannot be effectively processed by the patient either due to the high infusion rate and /or volume or an underlying cardiac or pulmonary pathology
      Signs and Symptoms: New onset of exacerbation of ≥ 3 of the following within 6 hours of transfusion:
      - Acute respiratory distress (dyspnea, orthopnea, cough)
      - Evidence of positive fluid balance
      - Elevated brain natriuretic peptide (BNP)
      - Radiographic evidence of pulmonary edema
      - Evidence of left heart failure
      - Elevated central venous pressure (CVP)
   b. **Transfusion Related Acute Lung Injury (TRALI)**
      Definition: Acute hypoxemia with PAO2/fraction of inspired oxygen [FIO2)] ratio of 300mm HG or less combined and chest e-ray showing bilateral infiltrates in the absence of left atrial hypertension (ie, circulatory overload)
      Onset of TRALI is abrupt in association with transfusion
      Signs and Symptoms:
      - **No evidence of Acute Lung Injury (ALI) prior to transfusion**
      - **Acute Lung Injury onset during or within 6 hours of transfusion**
      - Hypoxemia defined by any of these methods:
      - PaO2/FIO2 ≤ 300mm Hg
      - Oxygen saturation is < 90% on room air
      - Other clinical evidence:
      - No evidence of left atrial hypertension (i.e. circulatory overload)
      - No temporal relationship to an alternative risk factor for Acute Lung Injury during or within 6 hours of completion of transfusion
   c. **Transfusion Associated Dyspnea (TAD)**
      Definition: Respiratory distress within 24 hours of transfusion that does not meet the criteria of TRALI, TACO or allergic reaction. Respiratory distress should not otherwise be explained by a patient's underlying or pre-existing medical condition.
      Signs and Symptoms:
      - Acute respiratory distress and occurs within 24 hours of transfusion and TRALI, TACO and allergic reaction and other underlying medical conditions ruled out.

Documentation – Complete the following:

1. Transfusion Record Form
   a. Signatures of personnel starting and stopping transfusion
   b. Signature of personnel verifying patients identity
   c. Date/Time started
   d. Date/Time stopped
   e. Vital signs **before the transfusion starts**, between the first 10 and 20 minutes of the transfusion and within 15 minutes after the transfusion is complete.

f. Consent signed Yes/No
g. If the patient is an infant has the infant blood screen been drawn? Yes/No
h. If blood or blood product is given under anesthesia check the box "□ Given Under Anesthesia see Anesthesia Record". This will direct healthcare providers to vital signs recorded by anesthesia to avoid duplication.

2. EMR on Blood Flow sheet
   a. Document time when unit was hung.
   b. Document normal saline use.
   c. Vital signs recorded at appropriate times as described above
3. Document any patient responses, treatments or further care that is not within normal limits.

Reference:

CDC. (n.d.). Biovigilance Component. *National Healthcare Safety Network (NHSN) Manual* . Retrieved from Center for Disease Control and Prevention: www.cdc.gov/nhsn June 2011 pages 18, 19, & 21

Circular of Information for the Use of Human Blood and Blood Components, AABB, American Blood Centers, American Red Cross, Armed Services Blood Program, August 2009.

Community Health Network Transfusion Committee 2011

Practice Guidelines for Blood Transfusion Developed by America Red Cross Biomedical Headquarters, April 2007

Recommendations from Indiana State Department of Health, October 2011

Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
AABB Technical Manual, 17th Edition, 2011

Approved by:	IV NPP Committee	Date:	3/2013
	Infection Control	Date:	5/2013
	Risk Management	Date:	5/2013
	Network Blood Management Officer	Date:	2/2013
Approved:	NPP Steering Committee	Date:	6/12/13

ADDENDUM 1

Complications From The Transfusion of Blood/Blood Products

1. **Hemolytic Reaction: Immediate**
   a. **Causes:** The patient receives red cells that are ABO incompatible, this results in the hemolysis of red blood cells. It happens most often due to a mismatch of blood rather than a crossmatching problem. The severity of reaction correlates with the amount of blood transfused.
   b. **Symptoms:** Fever, chills, pain the lower back/legs, chest tightness, dyspnea, nausea, vomiting, flushing, tachycardia, bleeding from a wound/IV site, feeling of impending doom.
   c. **Blood Products:** Whole Blood, Packed Cells, leukocyte reduced RBC's, washed RBC's, and deglycerolized RBC's.
2. **Hemolytic Reaction: Delayed**
   a. **Causes:** Patient develops RBC's antibody due to transfusion, the antibody hemolyzes RBC's that are incompatible.
   b. **Symptoms:** In the hospital, this will be detected as a decrease in HgB/Hct or an increase in bilirubin due to hemolysis of the incompatible red cells. You will usually not see the immediate, acute signs and symptoms.
   c. **Blood Products:** Whole Blood, Packed Cells, and all RBC products.
3. **Nonhemolytic Febrile Reactions**
   a. **Causes:** Leukoagglutinins react with WBC's. cytokines in donor plasma or bacterial contamination.
   b. **Symptoms:** Fever, chills, nausea, vomiting, headache, dyspnea.
   c. **Blood components:** RBC products, Platelets, FFP.

   Nonhemolytic allergic reaction:
   a. Causes: IgE antibodies
   b. Symptoms: Urticaria, pruritis, erythema, asthmatic symptoms, anaphylaxis, dyspnea and/or laryngeal edema.
   c. Blood Components: All products containing plasma including RBC products, platelet products, fresh frozen plasma, and Cryoprecipitate.
4. **Bacterial Contamination**
   a. **Causes:** This is a rare complication caused by bacteria in the donor blood, usually gram - negative organisms. Immunocompromised patients are at a high risk.
   b. **Symptoms:** Chills, fever, vomiting, abdominal pain, hypotension, shock.
   c. **Blood Products:** Whole Blood, Packed Cells, Platelets, Plasma, and Cryoprecipitate.
5. **Transmitted Diseases**
   a. **Causes:** HIV, Viral hepatitis, human te cell lymphocyte te virus I/II, syphilis, malaria, babesiosis, etc.
   b. **Symptoms:** Onset delayed, disease dependent.
   c. **Blood Products:** RBC products, Platelets, Plasma, and Cryoprecipitate.

ADDENDUM 1 PAGE 2

Complications From The Transfusion of Blood/Blood Products (continued)

6. **Circulatory Overload**
   a. **Causes:** The volume or rate of infusion exceeds the circulatory system's capacity. Usually seen in patients with underlying cardiac, renal or pulmonary disease; elderly or very young; or massive transfusion (defined as 10 or more units of blood in a 24-hour period.) The possibility of overload can be decreased by the use of packed cells rather than whole blood, an infusion pump and slow rate of infusion, and administration of diuretics as ordered, and transfusion of patients in an upright position.
   b. **Symptoms:** Usually have gradual onset and correlate with the amount of fluid infused; dysopia, cough, pulmonary congestion/edema, neck vein distention, tachycardia, peripheral edema.
   c. **Blood Products:** RBC Products, platelets, Plasma.
7. **Pulmonary Embolism**
   a. **Causes:** Air, clot or foreign material entering the bloodstream via the tubing. Blood filters aid in prevention of emboli.
   b. **Symptoms:** Sudden chest pain, dyspnea, cough, hemoptysis, anxiety, and hypotension.
   c. **Blood Products:** RBC Products, Platelets, Plasma, and Cryoprecipitate.
8. **Hypothermia**
   Blood is stored between 1-6° C (33-43° F) compared to a person's blood with a normal temperature of 37° C. The rapid infusion of large quantities of cold blood especially through a central catheter directly into the right atrium can cause a patient to become hypothermic and result in decreased heart rate, blood pressure, cardiac output, coronary blood flow and ultimately cardiac arrhythmia's and arrest. The use of a blood warmer should be strongly considered with these patients.
9. **Acidosis**
   An anticoagulant solution, usually Citrate-Phosphate-Dextrose (CPD), is added to the blood as it is collected. The pH of CPD solution is 5.6, but the buffering action of Whole Blood (7.4) produces a final pH of 7.1 in freshly donated blood. As blood is kept in storage, despite the hypothermic conditions, anaerobic metabolism occurs with the end products being lactic and pyruvic acids. Thus, blood stored for two days has a pH of 6.9 and continues to decrease to 6.5 after 14 days of storage. The low pH of stored blood usually causes no difficulty because it is diluted with the patient's own blood.
10. **Citrate Toxicity and Hypocalcemia**
    The citrate added to stored blood is a calcium-binding agent to prevent coagulation during storage. Normally the excess citrate is metabolized in the liver and excreted in the urine. Toxic levels of citrate accumulate when this process is ineffective because of impaired hepatic and/or renal function, or in massive transfusion. The additional citrate binds ionized calcium in the recipient's blood, which can lower the serum ionized calcium level to the point of depressed cardiac contractility.
11. **Hyperkalemia**
    Potassium levels in stored blood rise gradually as potassium is released into the plasma by red cells lysis. The American Association of Blood Banks reports that the average amount of Potassium in one unit of 21-day old Whole Blood is 4mEq. This does not normally cause problems, except rarely in patients with impaired renal function.

ADDENDUM 3

BLOOD PNEUMATIC TUBE TRANSPORT

Mid America Clinical Laboratories
Indianapolis, IN 46219

REQUEST	RECEIPT
Patient Information: Full Name, MR#, Room #, or Addressograph BB ID #, if applicable _____	I have received the ordered products and have verified acceptable condition. Initials _____ Date/Time _____
Product Requested: _____ Quantity: _____ Tube Station: _____ Phone #: _____ Initials: _____ Send request form via pneumatic tube.	IMMEDIATELY UPON RECEIPT OF PRODUCT, RETURN THIS COMPLETED FORM TO BLOOD BANK VIA PNEUMATIC TUBE.

Date/Time Product Sent: _____ To be completed by Blood Bank
If requested product is not received within 30 minutes, call the Blood Bank.

COMMUNITY HOSPITALS OF INDIANA, INC.

1500 N. RITTER AVENUE
INDIANAPOLIS, IN 46219

INSTRUCTIONS TO PATIENTS RECEIVING BLOOD OR
BLOOD COMPONENT TRANSFUSIONS

Your physician has requested that you be transfused with a blood product. While the great majority of blood transfusions are accomplished without complications, a small number of persons who receive blood may experience one or more of the following symptoms within a few hours of receiving the blood product:

1. Hives
2. Itching of skin
3. Redness or flushing of skin
4. Fever or chilling sensation
5. Shortness of breath
6. Very dark or black urine

These symptoms will usually disappear in a matter of hours but report them to your physician as soon as possible.

During the next 2-3 months, if you develop any onset of fever/chills, fatigue, aching pains, or yellow skin color please contact your physician. Any other change in your condition should also be reported right away.

The symptoms above may not be a complete list of possible adverse effects of blood transfusions. You should call your physician regarding any other problem or symptom.

Date:_____

Signature: _____

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] TIHH
CANCELS: 8/30/09

NPP#: I-14, B-02
Page 1 of 2
EFFECTIVE: 5/23/12

Approved For:
☒ CHE ☒ CHN ☒ CHS ☒ TIHH

TITLE: BLOOD, UNCROSSMATCHED

Performed by: RN, LPN, Administrative Partner, EMT-P, EDCT, PSP And PST

Purpose: To outline the process for obtaining blood and blood products before completion of crossmatch testing.

Policy Statements:

1. The record will contain a signed statement from the ordering physician indicating that the clinical situation was sufficiently urgent to require release of blood.

General Information:

1. Blood Bank never releases red blood cells solely on a blood type based on a historical record.
2. The Blood Bank stock O-Rh-negative red blood cells for emergency release.
3. The blood bank stocks AB or A plasma for the emergency release of plasma.
4. If O Rh-negative red blood cells are unavailable, then O Rh-positive red blood cells may be used after consultation with the Blood Bank Medical Director and/or attending physician.
5. If the ABO of the patient is determined before compatibility testing is completed, the Blood Bank will switch to ABO compatible components.
6. The Blood Bank Medical Director and the attending physician are notified by Blood Bank immediately of any abnormal testing results that may affect patient safety.

Equipment: None

Procedure:

1. Request Emergency Release of Blood when the physician deems that the need for blood and blood components is necessary prior to the completion of compatibility testing
2. Place order in the computer for blood products requested.
3. Obtain specimen for crossmatch as soon as possible.
4. Call the Blood Bank and inform them for the need for Uncrossmatched blood and give the following information (if available)
   A. Patient name
   B. Patient date of birth
   C. Medical Record Number
   D. Physician's Name

E. Number of units requested.

3. Obtain the number of requested units from the Blood Bank along with the transfusion record form. NOTE: Each has a bright orange Uncrossmatched label on each unit of blood.
4. Obtain physician signature for the transfusion of Emergency Release.
5. Administer blood per Blood Administration Policy I-014 B-01, "Blood Component Administration".
6. Place original copy of the Transfusion Record Form on the patient's Medical Record Chart and return the 2nd copy to Blood Bank.

Documentation Guidelines:
Document blood administration in electronic medical record and complete Emergency Release Transfusion Record Form

References: Standards for Blood Banks and Transfusion Services, AABB, 27th Edition, 2011
AABB Technical Manual, 17th Edition, 2011

Approved by:	IV Advanced Practice	Date: 4/30/12
	Risk Management	Date: 3/21/12
	Infection Control	Date: 2/29/12
Approved:	NPP Steering Committee	Date: 5/9/12

BB.Misc.4.0 Critical Blood Supply Policy

STATEMENT OF PURPOSE

To outline the steps to be taken Mid America Clinical Laboratories when there is a notification from the blood supplier of a "Critical Blood Shortage".

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

POLICY

A. The site blood supplier notifies the Transfusion Service(s) (Medical Director, Blood Bank Supervisor or designee) that the blood supply is at a critically low level.

B. The supervisor/designee of each blood bank performs on immediate inventory of products on hand and communicates this to the Medical Director.

C. The Laboratory Medical Director contacts Transfusion Committee Chair(s) and together with the Blood Bank Supervisor(s) reviews immediate needs for blood products (crossmatch requests) needed for upcoming surgery. If a decision is made that current blood inventory may not meet anticipated need, elective surgical cases may need to be postponed or rescheduled. In this case the following people/departments are contacted:

1. Surgeons involved
2. Surgery Managers
3. Surgery Scheduling
4. Corporate communications officer
5. Chief of Medical Staff

Depending on the urgency and projected length of the blood shortage, consideration may be given to an urgent email notification of the entire Medical Staff.

D. Emergency requests for blood (intraoperative, ED, Labor and Delivery) should be immediately crossmatched and issued. If crossmatching is not possible due to the urgency of the request, follow policy for emergency release of blood.

E. With the resolution or easing of the blood shortage, the contacted individuals in section C shall be informed/updated.

4. REFERENCES

CHI Critical Blood Supply Policy
St. Vincent Hospitals and Health Services, Carmel and Indianapolis, Blood Shortage Notification Flow Sheet
St. Vincent Hospitals and Health Services Blood Shortage Memorandum

WRITTEN BY: Dr. Terry Cudahy and Dr. David Powers

IMPLEMENTATION DATE: April 2000

MID AMERICA CLINICAL LABORATORIES
MACL

BB.GEN.2.0 **Minimum Inventory**

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

- **Community North**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	25	10	25	4					
RINF		1							<5 days, CMV=,LR,IRR pedi bags attached
Plasma	20		20		8		8 (at least one unit of ped plasma)		
Cryo			10 or 2 pools of 5				1 single or 1 pool		
Platelets	1 AB or A Rh neg or positive								CMV=,LR,IRR, pedi bags attached

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.
- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

BB.GEN.2.0 Minimum Inventory

STATEMENT OF PURPOSE

To define the minimum levels of blood products to be available at all times.

SCOPE

This procedure applies to all Mid America Clinical Laboratory Blood Banks.
(Each site will have a specific minimum level.)

MINIMUM INVENTORY PER SITE

- **St. Vincent - Indianapolis**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	100	40	100	20	15	6			
RINF	4	4	4						All CMV Negative & prestorage leukoreduced.
Plasma	20		30		10		20		
Cryo	4 pools		4 pools		4 pools		10 single cryo 4 pools		*Pools =pool of 5 units
Platelets	• 4 Platelet pheresis, any type for general population. • 2 A+/= platelet pheresis, for trauma • 1 AB +/= or A+/=, CMV negative, for neonatal use.								2 platelet phereis for general population to be CMV negative
Rh Immune Globulin	25 vials								

- **St. Vincent – Women's**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	8	10	6					
RINF		4							CMV Neg, LR, IRR
Plasma			8		2		4 adult 8 pedi		
Cryo			1 pool				5 single		
Platelets	1 A or AB								
Rh Immune Globulin	25 vials								

MACL Minimum Inventory

- **St. Vincent - Jennings**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	6	2					

- **St. Vincent Salem**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	8	4	8	4					
Rh Immune Globulin	2-5 vials								

- **St. Vincent – Fishers (North East Medical Center)**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL		4*							2 CMV neg & Irr
Rh Immune Globulin									

- **St. Vincent - Carmel**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	8	12	4		2	0	0	
RNF		1							
Plasma	4		4				6 - 1 AB infant		
Cryo	5		5						
Rh Immune Globulin	2 boxes of 10 vials each								

- **St. Vincent - Mercy**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	7	4					
Plasma							6		
Rh Immune Globulin	4								

MACL Minimum Inventory

- **St. Vincent - Randolph**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	4	3	4	2	1	1			
Plasma							4		
Rh Immune Globulin	10								

- **IOH**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	5	6	6	4					
Plasma							6		

- **St. Vincent - Dunn**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	4*	6	4					• 2 CMV neg
Plasma							4		
Rh Immune Globulin									

- **St. Vincent - Anderson**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	22	6	22	6	5	2	2	2	
Plasma	6		6		6		6		
Rh Immune Globulin	10								

- **St. Vincent – St. Joseph Kokomo**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	10	4	10	4	2				
Plasma	6		6		4		4		
Rh Immune Globulin									

MACL Minimum Inventory

- **Community North**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	25	10	25	4					
RINF		1							<5 days, CMV=,LR,IRR pedi bags attached
Plasma	20		20		8		8 (at least one unit of ped plasma)		
Cryo			10 or 2 pools of 5				1 single or 1 pool		
Platelets	1 AB or A Rh neg or positive								CMV=,LR,IRR, pedi bags attached

- **The Indiana Heart Hospital**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	6	10	6	4					
Plasma	20		20		4		4		
Cryo	4		4		4				
Platelets	2*								

* 2 units of apheresis platelets will be kept on site Monday-Friday during normal surgical hours (6:30am-5pm). After normal hours, weekends and holidays a minimum of one unit will be kept on hand, if supply is available. Standing order of platelets is delivered on the following time table: Monday 2 units, Tuesday and Wednesday 3 units, Friday 1 unit. If patients are stable and the need is not emanate for the use of platelets, in order to conserve the product, the blood bank will not order additional units of platelets to arrive before the standing order.

- **Community Hospital East**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	20	10	20	10					
Plasma	10		10		10		10		
Cryo			2 pools						
Platelets	1 apheresis available								

- **Community Hospital South**

Product	O+	O=	A+	A=	B+	B=	AB+	AB=	Notes
RL	12	10	12	6		2			
RINF		1							LR,IRR,CMV- with ped bags attached. Fresh one delivered on Friday
Plasma	4		4				4		
Cryo	2 pools								
Platelets	1 apheresis available								

- **RL** = Red Cells Leukoreduced **RINF** = Red Cell Infant: <5days, Irr, LR, CMV neg
- Inventory is to be taken each shift. The Blood Bank associates are responsible for maintaining the minimum inventory and for calling the blood supplier for restock.
- When inventory falls below minimum levels, sufficient blood products should be ordered to maintain minimum inventory levels.
- Both the Indiana Blood Center and American Red Cross will network with other FDA approved blood centers to obtain blood products in the event of a local shortage.
- Blood products may be obtained from other Mid America Clinical Laboratories facilities in the case of a site-specific shortage.

WRITTEN BY: Beth Hughes

IMPLEMENTATION DATE: Jan 2000

BB.Issue.1.0 Emergency Release of Blood Components

STATEMENT OF PURPOSE

To outline steps to be taken for release of:

a) Uncrossmatched red cells in an emergency situation;
b) Release of plasma and platelet products when an ABO/Rh type is not available.
c) Product selection for Neonatal Emergency Release.

SCOPE

This document applies to all Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.ABO/Rh.1.0	ABO Blood Grouping
BB.ABO/Rh2.0	Rh testing – D and Weak D
BB.IAT/DAT.1.0	IAT – Indirect Antiglobulin Testing
BB.TYSC/TRBC.1.0	Compatibility Testing – Required Testing
BB.Issue.2.0	Dispensing of Blood Components
BB.TYSC/TRBC.6.0	Selection of and Indications for Products for Transfusion
BB.Issue.8.0	Preparation of Emergency Release Container

SPECIMEN

EDTA or Clot tube as described in BB.Spec.1.0

MATERIALS

Emergency Release Container in BB refrigerator:

- 2 to 4 units of O negative red cells
- TRF with completed Emergency Release Block
- Orange Uncrossmatched Blood stickers
- Labeled segments from each issued unit
- Optional: Make a Xerox copy of each unit label in the container to scan when the emergency release units are allocated and issued after crossmatch is complete.

PROCESS

I. **Neonatal Emergency Release**

In the event that blood is need emergently for a neonate, the following product will be released:

- O negative
- Irradiated
- CMV negative
- Freshest unit available, preferable less than 5 days.
- If irradiated and or CMV negative blood is not available, contact the transfusion physician on possible product substitution, as in CVM not required due to red cells being leukoreduced.

II. **MACL Staff Available**

A. **Blood Product Selection**

1. Based upon available history, if the patient has special needs, then immediately consult Medical Director/pathologist on call. If history indicates patient has antibodies, notify ordering physician immediately of unavailability of compatible product. However, **DO NOT REFUSE** to give potentially incompatible product if warranted.
2. Each Blood Bank will routinely stock at least 2 units of O negative red cells for Emergency release.
3. If O negative blood is unavailable, do not delay releasing blood, but issue O positive red cells
4. O positive blood should not be given to women less than 55 years of age or pediatric patients unless Medical Director and/or patient's physician have been consulted
5. **NEVER** give Red Cells Products based on historical type.
6. If the contents of the Emergency Release Container are transfused, the container needs to be restocked at the earliest time possible. See BB.Issue.8.0 Preparation of Emergency Release container.

B. **Emergency Release No Specimen Available**

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request: Patient name MR# Transfusing physician Number of units	**Patient information may not always be available. In emergency situations gather as much identifying information as available.**
3	State need for blood bank specimen as soon as possible.	

4	Remove either of the following: • Emergency Release Container • 2 units of either O neg or O positive blood (dependent on the age and sex of the patient)	See BB.ISSUE.8.0 Preparation of Emergency Container.
5	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
6	Complete Emergency Release Block of the Transfusion Record Form.	
7	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
8	Issuing tech signs "Issued By" line of Emergency Release Block.	
9	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
10	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number. • Unit type • Exp. date	
9	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.

C. Emergency Release – Specimen Available

Step	Action	Notes
1	Receive call requesting uncrossmatched blood.	
2	Request the following information: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.

4	Select type specific red cells if there is current TRBC or TYSC order.	• A current specimen is one drawn within the last 3 days. Order as additional red cells. • Perform an eXM if IAT is negative. • If patients requires AHG crossmatch, contact pathologist and/or attending physician with patient's history.
6	If antibody screen was positive, or patient has a history of positive antibody screen, retain one segment from each unit. Label segment with unit number.	
7	Complete "Emergency Release Block" of Transfusion Record Form.	Up to 4 units may be initially released. **(Exception:** Surgery may be given more depending on circumstances.)
8	Write available patient information on orange "Uncrossmatched Blood For" label on each unit.	Must include at least patient name and MR# if available.
9	Place orange "Uncrossmatched Blood For" label on each unit.	
10	Prepare units for transport in blood box, if utilized.	Use of box is preferable, but not mandatory in an emergency.
11	Issuing tech signs "Issued By" line of Emergency Release Block.	
12	Transporter brings documentation of patient to received Emergency Issued product.	Documentation should be as much information as is available at the time of release, i.e. Name: John Doe MR#: if available BBID: if used
13	Perform read back procedure for the issue of blood between transporter and blood bank associate. • Any patient information that is available • Unit number • Unit type • Exp. date	
14	Emergency release to a transporter: a. Transporter signs "Transported By/Received By" line of Unit Transportation Block. b. Retain bottom copy of Transfusion Record Form. c. Send top 2 copies of Transfusion Record Form with unit(s).	Transporter is defined as an appropriately trained MACL or hospital employee. Use copy to help track units and documentation of physician signature.
15	Upon completion of testing: • Enter testing results in computer • Dispense units in the computer • Unit comment:";ISUN"	ISUN = Units issued Uncrossmatched.

D. Emergency Release – Testing and Paper Work Completion

Step	Action	Notes
1	**Perform** ABO/Rh immediately upon receipt of a properly labeled specimen.	If unable to obtain specimen due to patient demise, enter comment in patient history (e.g., "Patient specimen never received for crossmatch.") See computer steps.
2	**Perform** antibody screen. If negative, **allocate** units and **electronically crossmatch** emergency released units. Notify floor of completed antibody screen results.	If additional units are ordered, select ABO compatible units and continue with electronic crossmatch.
3	**--If positive antibody screen results are obtained, notify requesting physician immediately.** **--If physician wishes to continue with the transfusion, ensure yellow copy of transfusion record form has been signed by that physician.** **--If physician decides to continue transfusing, perform gel crossmatch using segments from units that were emergency released.** **--If crossmatch incompatible, notify physician IMMEDIATELY.** **--Proceed with antibody identification.**	**"Contact Supervisor/Designee and Medical Director."** **Enter** a BBCMT comment to indicate name of physician called, date, time, and initials of tech entering comment. **Write** same comment on the requisition: name of physician notified, date, time and initials of tech doing the notifying.
4	**Verify** that a type and crossmatch has been ordered.	
5	**Receive** orders.	
6	**Record** patient results in the computer.	
7	**Discard** printed Transfusion Record Forms after allocation of units and crossmatch results are entered.	**Hand written Transfusion Record Form is the permanent record.**
8	**Issue units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	See BB.Issue.2.0 Dispensing of Blood Components.
9	Paper work follow up: • Keep pink copy in view for reminder of follow up till yellow copy received from nursing unit. • Obtain yellow copy of Transfusion Record Form with physician's signature. • File yellow copy in blood file labeled "Emergency Release.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

II. MACL Staff Unavailable – Sites without staffing 24/7

NOTE: Red cell products shall be made accessible for emergency transfusion at all MACL hospital based lab sites that are not staffed continuously. These blood products must be easily identifiable by non MACL staff and must be labeled appropriately. The necessary accompanying paperwork should be stored with the red cells.

A. Blood Product Selection and Release – Utilizing Emergency Release Container

Step	Action	Notes
1	Patient requires emergency transfusion at a time when the laboratory is not staffed.	
2	An appropriately labeled blood bank specimen should be obtained on the patient prior to transfusion.	
3	An order for crossmatch must be placed in the hospital computer system.	
4	Nurse or physician enters blood bank area and removes the "Red Cells for Emergency Transfusion" container from the blood bank refrigerator.	
5	Following the "Nursing Instructions for Emergency Transfusion", the blood transporter (nurse or physician) completes the indicated portion of the Transfusion Record Form.	
6	Transporter (nurse or physician) fills out patient information on the orange "Uncrossmatched Blood For" label.	
7	Transporter (nurse or physician) takes top two copies of the Transfusion Record Form with the units and leaves the bottom copy for the laboratory staff.	
8	Transporter (nurse or physician) will obtain the ordering physicians signature in the appropriate area of the Transfusion Record Form. The signed copy MUST be returned to the blood bank.	
9	Units that are not transfused must be returned to the blood bank refrigerator within 30 minutes. Accompanying paper work must also be returned.	

B. Emergency Release Specimen Work Up by MACL Staff

Step	Action	Notes
1	Perform blood type, antibody screen and crossmatch testing on the pretransfusion specimen.	Send the specimen to CTS if staff is not present to perform testing.
2	Notify patient care area of the results when testing is completed.	

3	Discard the Transfusion Record Forms that are generated during result entry If the units have been transfused. **The handwritten Transfusion Record Form is the permanent record.**	If the units have been returned to the blood bank, they may be relabeled with the computer generated Transfusion Record Forms.
4	**Issue any transfused units in the computer in Blood Product Issue Function:** At the **"Issue Comments" field** (within Issue Information Area): **Type ISUN** **TAB (ISUN populates with Issued Uncrossmatched).**	
5	Obtain the yellow copy of the Transfusion Record Form that is completed with the physician's signature documenting the emergency release. File appropriately.	When finalized, one copy should be retained on patient's chart (white copy). Signed yellow copy is retained in blood bank for at least one year. (Permanent record in patient's chart.)

III. Plasma or Platelet Products

- If MACL staff is unavailable, patient care staff follows "Nursing Instructions for Emergency Transfusion".

Step	Action	Notes
1	Receive call requesting plasma products.	FFP, Cryo or Platelets
2	Request: Patient name MR# Transfusing physician Number of units	Patient information may not always be available. In emergency situations gather as much identifying information as available.
3	Perform history check, if no historical type is available, issue the following: **FFP- type AB** **Platelets – any type available** **Cyroprecipitate- A or O**	**NOTE: Up to 500 mls of incompatible plasma may be given in 24 hours without notification of Medical Director.**
4	State need for blood bank specimen as soon as possible.	
5	Upon receipt of properly labeled specimen, perform blood type and proceed with giving type compatible products.	

COMPUTER STEPS

1. Completing Sample Testing Results in Function Blood Order Processing after Emergency Issue

Step	Menu Selection	Action	Notes
1.	Blood Order Processing	Enter patient's MR# in the "Value" field and select appropriate patient.	M# must be entered from patient's specimen tube.
2.		Select Order Selection tab.	
3.		Select accession number.	
4.	Patient Specimen	Perform and enter patient test results.	See computer steps in BB.ABO/Rh.1.0 ABO Blood Group Testing BB.ABO/Rh.2.0 Rh Testing- D and Weak D BB.IAT/DAT.1.0 IAT-Indirect Antiglobulin Testing. **If unable to obtain specimen due to patient demise, order BBCMT in "add spec. test" field. Free text ; Patient specimen never received for crossmatch. Add date and initials of tech commenting.**
5.	Allocation	Press **Allocation tab.** Place cursor in **Unit #** field. Enter unit number of each unit issued. Sites that make a copy of emergency kit unit labels will be able to scan the unit number from the Xerox copy. Press **Select.**	Perform crossmatch methodology required for patient. BB.TYSC/TRBC.1.0 Compatibility Testing -- Required Testing BB.TYSC/TRBC.2.0 Electronic Crossmatch BB.TYSC/TRBC.3.0 Crossmatch - IS BB.TYSC/TRBC.4.0 Crossmatch- AHG
6.		Click on **Save** button.	

REFERENCES

Standards for Blood Banks and Transfusion Services, AABB, Current Edition.
AABB Technical Manual, Current Edition.

WRITTEN BY: Pat Smith, MT (ASCP)

IMPLEMENTATION DATE: January, 2000

QA.GEN.1.5 MID AMERICA CLINICAL LABORATORIES SCOPE OF SERVICES

I. Mission

Our mission is to be the leading Indiana provider of quality clinical laboratory services achieved through the expertise, commitment, and creativity of our associates.

II. Scope of Services

Laboratory Testing Facilities

Mid America Clinical Laboratories includes a network of Hospital-Based Laboratories, Laboratory Service Centers, Point-of-Care Testing (POCT) services, and a Regional Reference Laboratory.

Hospital-Based Laboratories—The Hospital-Based Rapid Response Laboratories (RRL) perform stat and some routine testing 24 hours a day, 7 days a week, as necessary for appropriate patient care at each hospital location. Testing at these laboratories includes the following disciplines:

- Chemistry
- Coagulation
- Hematology
- Immunohematology (Blood Bank)
- Rapid and Routine Microbiology
- Urinalysis

Regional Reference Laboratory—The Regional Reference Laboratory performs routine and esoteric testing in the following clinical pathology disciplines:

- Chemistry
- Coagulation
- Gynecologic Cytology
- Hematology
- Immunohematology (Blood Bank)
- Immunology

- Microbiology (including Bacteriology, Mycology, Virology, Parasitology and Mycobacteriology)
- Molecular Diagnostics
- Urinalysis

Much of the testing at the Regional Reference Laboratory is performed overnight, to better support patient care by allowing at most 24-hour turnaround time for most routine, and some esoteric tests. Hours of service vary by department or testing area. This facility may be contacted through Customer Services.

Point-of-Care Testing—Point-of-Care Testing is performed and/or managed in many locations, including hospital patient care units, emergency departments, outpatient clinics, surgery centers and MACL Patient Care Centers (PCCs). MACL provides POCT oversight management or assistance to hospital clients to ensure all regulatory requirements are met. These services include: selection of POCT devices, training, review of data, performance of linearity/correlation studies, procedures, logs, investigation of new methods, proficiency testing selection and review, etc. A certified medical technologist and several POCT service representatives staff the department to support this program.

Laboratory Accreditation and Quality Assurance—MACL is accredited by the College of American Pathologists (CAP) and, for the St. Vincent Indianapolis Blood Bank, the American Association of Blood Banks (AABB). Both the CAP and the AABB are deemed accrediting agencies for the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Clinical Laboratory Improvement Amendments (CLIA), which is the set of Federal regulations covering clinical laboratory practices. Additionally, MACL services are monitored and approved by the Indiana State Department of Health (ISDH) and the Food and Drug Administration (FDA).

Board-certified pathologists direct all laboratory activities, providing medical and technical support services on a full-time basis. Well-trained and competent medical technologists, cytotechnologists, analytical scientists, medical laboratory technicians, and lab assistants enable MACL to provide precise and accurate test results. Day-to-day quality and accuracy are assured by internal quality control and external proficiency testing programs, as well as extensive competency assessment protocols. A comprehensive quality management program provides both guidance and monitoring of testing quality and service effectiveness.

Safety—MACL complies with all applicable safety and environmental requirements established by federal, state and local authorities (eg, OSHA, EPA, IDEM, ISDH).

Results Reporting Services—In accordance with regulations governing clinical laboratories and in order to maintain the confidentiality of personal health information, it is MACL policy to release test-related information only to the person who requested the test or to that person's representative.

Computer generated reports are charted in the hospitals or sent to physician offices or outside facilities by the best available means of communication: electronically, by courier, or by mail.

Reference ranges (normal ranges) with interpretation of results as indicated will be included on each patient test report. Because of continuing improvements in methodology and expanding knowledge in clinical interpretation, reference ranges do not remain static in a progressive laboratory. Each report will carry current reference ranges for the specific test.

Alert or critical results are flagged in the laboratory computer system when they exceed the verification range. All alert values are telephoned to the nursing unit or the physician. For those tests with established turnaround times, the laboratory will evaluate the urgency of the test result requested and notify the appropriate nursing unit or physician.

Turnaround times for STAT tests performed on site at the Hospital Based RRLs will be one hour or less from receipt in the laboratory. Turnaround times for routine tests performed by the Regional Reference Laboratory will be less than 16 hours. Most microbiology testing, esoteric testing, and gynecologic cytology will be available in 48 to 72 hours; dependent upon methodology. When appropriate, microbiology preliminary reports are often available after 24 hours.

Rapid Response Laboratory (RRL) Test Availability—Rapid Response Laboratory test menus vary slightly, dependent upon the needs of the facility's patient population and service mix. STAT orders for testing are targeted for result availability within 30 minutes for emergency department (ED) requests and 45 minutes for non-ED requests. The basic RRL test menu includes the tests shown in the table below. Again, this menu varies based on facility need due to patient population and service mix (eg, a facility offering transplant services may require the ability to monitor some transplant drug concentrations in their patients, another location may service patients who do not require some of the tests listed, such as gentamicin).

Rapid Response Laboratory (RRL) Sample Test Menu		
Acetaminophen	CPK	Occult Blood, Gastric
Acetone	Creatinine	Osmolality, Blood/Urine
Alanine Aminotransferase (ALT)	Crossmatch	Phosphorus
Albumin	D-Dimer	Platelet Count
Alcohol	Digoxin	Potassium, Serum/Plasma/Blood
Alkaline Phosphatase	Dilantin	Protein, Total, Blood
Ammonia	Direct Antiglobulin Test	Protein, Total, CSF
Amylase	Drug Screen, Urine (Triage)	Protime (PT, Prothrombin Time)
Antibody Screen	Electrolyte Panel, Blood	PTT (Partial Thromboplastin Time)
Antibody Screen, prenatal	Gentamicin	RBC Count
Aspartate Aminotransferase (AST)	Glucose, Blood	Renal Function Panel
Bacterial Vaginosis (BV)	Glucose, CSF	Respiratory Syncytial Virus (RSV)
Basic Metabolic Panel (BMET)	Glucose, Post Prandial, 2 hour	Rh Typing (includes weak D)
Bilirubin, Direct	Glucose Tolerance (various)	Salicylate
Bilirubin, Direct-Neonatal	Gram Stain	Sedimentation Rate
Bilirubin, Total	Group A Strep Screen	Sodium, Blood
Bilirubin, Total-Neonatal	HCG, Qualitative, Blood	Specific Gravity, Urine
Blood Type	HCG, Qualitative, Urine	Tegretol/Carbamazipine
BNP	HCG, Quantitative, Serum	Trichomonas Rapid Test (TRS)
BUN	Hematocrit	Trich Prep
Calcium	Hemoglobin	Troponin I
Calcium, Ionized	Hepatic Panel	Type and Crossmatch
Carbon Dioxide (CO2)	HIV 1/2 (Suds) Needlestick Protocol	Uric Acid, Blood
Carbon Monoxide (CO)	India Ink Prep	Urinalysis (UA)
CBC (no Differential)	Influenza A & B	Urinalysis Microscopic
CBC with Differential	Iron, Total	Urine, Ketone
Cell Count, Body Fluid	Lactic Acid, Blood	White Blood Cell Count
Cell Count, CSF	LDH	
Cell Count, Joint Fluid	Lipase	
Chloride	Magnesium	
CKMB	Mono Screen	
Clostridium difficile—Rapid	Myoglobin	
Comp. Metabolic Panel (CMET)	Occult Blood, Fecal	

Client Services

MACL recognizes that the laboratory's quality is defined by both technical and service quality. We will continually strive to understand, respond to, and meet the needs of our clients by functioning as their advocate; recognizing and responding to service opportunities and facilitating resolution.

The Client Services Department is available:

Monday – Friday	24 hours/day
Saturday	12:00 AM – 3:30 PM (RRLs take calls after 3:30 PM)
Sunday and Holidays	7:00 AM – 3:30 PM (Closed Christmas Day; RRLs take calls after 3:30 PM)

Client Services addresses all customer inquiries relative to specimen requirements, test results, test information, and duplicate reports or report retransmission, along with other questions and concerns.

Courier Services/Specimen Pick-up

Courier service is designed to meet the needs of our customers for specimen pick-up, and report and supply delivery to hospitals, clinics, physician offices, and nursing facilities throughout our service area.

Patient Care Centers

MACL has more than 20 Patient Care Center (PCCs) throughout Central Indiana. In addition to these locations, outpatient draw sites are located in many of our affiliated hospital locations. Hours for the hospital-based PCC locations are, at minimum, Monday-Friday 8 AM to 5 PM; some locations have Saturday hours. Information on specific locations is available through Client Services and the MACL webpage (www.maclonline.com) These PCCs are staffed with Phlebotomists who are required to complete competencies in age-specific training in phlebotomy and specimen preparation, including annual recertification in all areas. All associates undergo extensive compliance training, which includes coverage of HIPAA requirements.

Beyond these MACL-specific PCC locations, we have numerous in-office phlebotomists placed in clinics and physician practices throughout Central Indiana.

indiana
BLOOD CENTER

SERVICES AGREEMENT

PROVIDED BY:

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

PROVIDED TO:

Community Hospital North
7150 Clearvista Drive
Indianapolis, IN 46256

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 NORTH (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

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 eight (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 North Robert Lindeman, MD, Interim President 7150 Clearvista Drive Indianapolis, IN 46256

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]

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 North

By: [illegible]
Robert Lindeman, MD, Interim President

7/2/13
Date

APPENDIX A
BLOOD AND BLOOD PRODUCT SERVICES
Community Hospital North

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 North

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
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

DESCRIPTION	SUGGESTED P-CODES	ITEM CODE	PRICE ($)
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

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	12.50
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

DESCRIPTION	SUGGESTED CPT-CODES	ITEM CODE	PRICE ($)
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 Phenotye	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.

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
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

DESCRIPTION	SUGGESTED CPT CODES	PRICE ($)
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	83891,83896x224,83898x3,83912	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 BBB Date 6-27-13

Client:

Initial RC Date 1/2/13

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 AW 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 RL Date 7/2/13

APPENDIX X
SERVICES AGREEMENT – COMMITTED VOLUMES
COMMUNITY HOSPITAL NORTH

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:

Product Unit	Price per Unit ($)	Annual Unit Quantity or % of Annual Purchased Amount
LRC	215.00	4,570
APLT	500.00	550
FP24	50.00	900
CRYO	43.00	0
POOLED CRYO	300.00	20

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.

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Total
LRC	1,158	1,146	1,120	1,146	4,570
APLT	139	138	135	138	550
FP24	228	225	221	226	900
CRYO	0	0	0	0	0
POOLED CRYO	5	5	5	5	20

II. DELIVERY AND TRANSPORTATION

A. Routine delivery. The Blood Center shall provide scheduled delivery one (1) time per weekday (Mon-Fri) and once Saturday morning at no charge.

B. Additional delivery. Deliveries requested by the Client beyond the routine delivery 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 an additional fee of:

One-way fee	$20.00
Round-trip fee	$40.00

C. 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.

D. 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 6-24-13

Client:

Initial RIC Date 7/2/13

BB.TYSC/TRBC.6.1 NURSING GUIDE FOR RED CELL SUBSTITUTUIONS

The following explanation may be sent with red cell units that are non ABO/RH identical.

Whenever there is a blood shortage from our blood suppliers (Indiana Blood Center or American Red Cross), the possibility exists that patients may receive a unit different from their own blood type. The following chart lists the acceptable blood type substitutions.

Red Cell Product Transfusion

A. Substitution Table - **ABO**

Patient Type	Acceptable ABO TYPE
O	O
A	A, O
B	B, O
AB	AB, A, B, O

B. Substitution Table – **RH**

Patient Type	Acceptable Rh TYPE
Rh positive	Rh positive or Rh negative
Rh Negative	Negative OR positive if inventory warrants with the following guidelines: 1. Patient is a male 2. Female older than 55 years of age or consent has been obtained from the Medical Director. 3. Patient does not have the Anti-D antibody.

BB.Recv.4.0 OBTAINING BLOOD COMPONENTS

STATEMENT OF PURPOSE

The purpose of this document is to outline the process for ordering blood components from suppliers.

SCOPE

This process applies to all Mid America Clinical Laboratory Blood Banks.

RELATED DOCUMENTS

BB.Gen.2.0	Minimum Inventory (Site Specific)
BB.Recving.1.0	Receipt, Inspection, Storage and Disposal of Blood Components and Reagents
BB.Misc.5.0	Indiana Blood Center Critical Policy

PROCESS

Standing Orders are established for all hospital sites with our blood suppliers. These standing orders apply to red cell and platelet products. Standing order blood components for sites in the Indianapolis area will be delivered to the CTS (Centralized Transfusion Service) for processing and distribution to hospital sites. Standing orders may be altered by either CTS or the respective hospital site when inventory needs change.

If a site hospital changes a standing order scheduled to be delivered to CTS, CTS is to be notified of the change. If CTS does not receive a scheduled standing order, they notify the site hospital.

When red cell products or platelets are needed immediately, the hospital site should contact the blood supplier directly and have the blood product delivered directly to the hospital site.
Plasma products and cryoprecipitate should be ordered by and delivered directly to the hospital site.

I. Placing Orders with IBC (Indiana Blood Center)

Step	Action	Notes
1	Phone distribution department, 317-927-1719 OR 317-916-5278	

2	When placing the order, the following information will be given: • Callers name • Facility's name • Product needed • ABO/Rh type needed • Number of units for each product/type needed. • Type of special run o Express: Orders are filled and picked up from IBC within 1 – 1 ½ hours from time order is placed o Stat: Stat orders will be filled and picked up from IBC within thirty (30) minutes form the time the order is packed or delivered immediately following packing into IBC STAT car. o Standard: Standard orders have a three hour window form pickup to delivery.	
3	Document order on Blood Supply Order Log, (BB.Recving.4.1) or any other documentation method.	
4	In the event of a disaster, IBC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Fort Wayne)

Step	Action	Notes
1	Phone distribution department, 1-800-589-8128.	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

Placing Orders with ARC (American Red Cross- Louisville)

Step	Action	Notes
1	Phone distribution department, [redacted]	
2	Place order.	State how and when shipment is to be made, i.e., Stat, routine.
3	Document order on Blood Supply Order Log.	
4	In the event of a disaster, ARC will make every effort to maintain the blood supply to its customers.	

REFERENCES

IBC Disaster Plan for Blood Product Supply.
IBC Blood Services Guide.
ARC Disaster Plan for Blood Product Supply.

WRITTEN BY: Kim Coors, MT (ASCP) BB

IMPLEMENTATION DATE: April 2000

BB.GEN.8.0 Verbal Orders for the Provision of Blood Components

STATEMENT OF PURPOSE

During emergent situations, there may be times when the entry of orders into the hospital order system may not be able to be completed in a timely manner. During these rare times, the blood bank may take verbal orders over the phone. After the crisis situation has been resolved, the nursing unit along with the ordering physician will ensure that written/electronic orders are sent to the blood bank per CLIA regulations. (42CFR 493.1241(c))

The purpose of this document is to outline the steps necessary to take when receiving verbal orders for the provision of blood components.

SCOPE

This protocol pertains only to Mid America Clinical Laboratories Blood Banks.

RELATED DOCUMENTS

BB.GEN.8.1 Verbal order form

PROCEDURE

The procedure for receipt and processing of verbal orders from surgical areas will be as follows:

I. Receipt of the verbal order:

A. Associates answering the phone in the blood bank will take the following information and document on the Verbal order form BB.GEN.8.1:

1. Patient's full name
2. Medical Record number
3. Blood Bank ID number if applicable
4. Patient's date of birth
5. Ordering physician's first and last name
6. Name of person giving the verbal order
7. Location
8. Component(s) being requested
9. Number of units requested for each component type.

B. Placing orders into Sunquest:
   1. In function REH, place the order for each component ordered and the amount requested
   2. Place the Sunquest order labels on the Verbal Order form BB.GEN.8.1

C. Processing the orders:
   Orders will be processed in Misys in the standard manner.

D. Follow up:
   1. Upon the completion of the case, the OR team will place the orders in the hospital order system.
   2. The blood bank associate will take the printed order requisition(s) from the printer and attach to the Verbal Order Form BB.GEN.8.1.
   3. The printed orders will be retained in the blood bank for a period of at least 3 months.

REFERENCES

42 CFR 493.1241(c):
AABB Standard 5.11.1, 27th Edition,
The Interpretive Guidelines §482.23(c)2(i) and §482.23(c)3

MACL Verbal Order Form BB.GEN.8.1

Patient Name:		
Medical Record Number		
Patient's DOB		
BBID(if Applicable):		
Surgical location/Rm #		
Ordering Physician: (First and Last Name)		
Name of person giving order		
Component (✔ if ordered)		Number of units
Red Cells		
Platelets		
Plasma		
Cyro		
Attributes: ( ) Irr ( ) CMV negative ( ) HgbS negative ( ) Other:_____		

History Checked by:_____

ABO/RH:_____ AG/AB:_____

Auto/DD units:_____ Comments:_____

Retype ABO/RH:_____

Place Sunquest Order labels Here:

Upon receipt of written orders attach to back of this form.

BB.GEN.7.0 RESOURCES - STAFFING

STATEMENT OF PURPOSE

This policy defines the determination of staffing levels within the blood banks and also defines the location and determination of job descriptions and qualifications.

SCOPE

This policy applies to all Mid America Clinical Laboratories blood banks

RELATED DOCUMENTS

MACL QUALITY PLAN

POLICY

A. Staffing requirements will be determined by the following criteria:
   1. Workload as determined by the IEB and workload recording programs in Sunquest.
   2. Overtime paid as determined by the payroll department.
   3. Staffing requirements for all shifts including weekends, holidays and vacations.
   4. The above criteria will be reviewed by the VP for Hospital Operations, HR and the site supervisor when staffing issues arise.

B. Role summaries are written and maintained in the Human Resources Department of Mid America Clinical Laboratories.
   1. Role Summaries are written by the Human Resources Department along with input from Directors and Supervisors.
   2. Job descriptions are maintained in the Human Resources Department residing at the Regional Facility on Shadeland Avenue.

C. Contingency Plans for staffing may include the following:
   1. Staff from other sites may be deployed to the area in need.
   2. Workload may be shifted to other sites (i.e. routine work may be sent to another location).
   3. Antibody identification and problem patients may be sent to the Reference Lab at Indiana Blood Center.

WRITTEN BY: Kim Coors, MT(ASCP)BB

IMPLEMENTATION DATE: Feb 2003

Community Hospital North

Indianapolis, Indiana

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

SECTION 16

Laboratory Services

"Laboratory Services: There must be laboratory services available twenty four (24) hours per day".

NARRATIVE RESPONSE AND DISCUSSION

The requirements of Section 16 are met with a signed letter of commitment from the Community North Laboratory Manager and Laboratory Medical Director affirming that Laboratory Services are available twenty four hours per day.

Community
Health Network

June 9, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 the Laboratory supports Community North Hospital'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.

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

Respectfully,

Kathy Braniff, MLS(ASCP)
Laboratory Manager

Norman Hurwitz, M.D.
Laboratory Medical Director

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community Hospital North

Indianapolis, Indiana

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

SECTION 17

Post-Anesthesia Care Unit

"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."

NARRATIVE RESPONSE AND DISCUSSION

Included in Section 17 is a letter of commitment from the Community North Director of Surgical Services affirming that the Post Anesthesia Care Unit has qualified nurses and available equipment available twenty four hours per day. There is also an equipment list for the PACU included.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 Nursing Director of the Post Anesthesia Care Unit. I am pleased to support Community Hospital North in the 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,

Marci Jones

Marci Jones, RN
Director of Surgical Services

Joseph Pavlik, M.D., FACS
Trauma Medical Director

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

Equipment Listing for CHN POCU/PACU:

- BairHugger Patient Warming units
- Blood Sugar meters (Accuchek)
- Computerized documentation
- Crash cart with defibrillator and external pacing capability
- Doppler
- End Tidal CO_2 Monitoring
- Glide Scope for video intubation
- Handheld blood analyzer for bedside diagnostic testing (I-STAT)
- Hotline Fluid warmers
- IV Pumps
- Monitors for basic vital signs and invasive monitoring
- Point of Care Ultrasound (Sonosite)
- Portable EKG
- Portable pulse oximetry
- Portable X-ray (Service provided by hospital Imaging Department)
- Temporal Artery Thermometers

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

Staffing and On Call Guidelines for CHN Surgery Personnel

Operating Rooms:

CHN Surgical Services is covered with staff (RN and/or CST) 24/7, with the exception being Holidays. Monday thru Friday, the department is staffed to run eight rooms until 3pm, five rooms until 5pm, and 2 rooms until 11pm. After 11p one person is staffed in the department with one person on call until 7am, providing the ability to run one room. Saturday and Sunday the department is staffed to run one room at all times.

Holidays, the OR maintains an On-Call staff consisting of three members (RN and/or CST). These staff members are to deliver care to the patients requiring emergency surgical procedures during the hours not covered by on duty personnel. Staff who are assigned, or who volunteer for this duty, are responsible for upholding the department's high standards of quality patient care and conducting their duties according to the policies and procedures set forth by the hospital and the department.

J/PACU:

The POCU/PACU is staffed M-F 5:00am- 10:30pm. From 6:00pm-6:00am, there will be two RN's in an on-call status to cover the POCU/PACU area, with a required arrival time of 30 minutes from notification. Weekends (Saturday and Sunday) will be staffed with two RN's from 6:00am – 6:30pm. Two RN's will be on-call to cover any activity in the POCU/PACU area from 6:30pm – 6:00am. First call person will cover the hours of 1830-0600; designated Second call person will cover call for a 24 hour period of time. During Phase One recovery, there will always be two RN's in the POCU/PACU area per ASPAN Practice Recommendations.

Procedure:

1. The on call physician will notify the staff of an emergency surgery. If you are called for a procedure scheduled for a specific time, all staff is expected to arrive to the hospital within 30 minutes of notification.
2. If a case cart is needed for the procedure, OR staff should call CSR [redacted] in advance so the supplies will be ready when the OR staff arrives.
3. Dress for duty per department policy.
4. In the event that the Surgery phone is forwarded (Holidays and unforeseen circumstances), un-forward surgery phones upon arrival so that calls are received on the [redacted] phone.
5. Prepare the OR and PACU for the procedure being done.
6. The patient is brought to the surgery department by either the On Call RN (usually the PACU RN) or the Nursing Unit/ED personnel. Transport and admit the patient per departmental policies.
7. Prepare the department for the next procedure/shift which includes:
   a. washing utilized instrumentation.
   b. Non-disposable items should be returned to their designated storage areas.
   c. Return case cart and supplies to CSR.
   d. Notify Environmental Services that the OR was used and needs cleaning.
   e. Cultures (and other lab specimens—except tissue histology) must be taken to the Laboratory at the completion of the case.
   f. The OR and PACU must be totally re-stocked.

Community Health Network

Surgical Services
7150 Clearvista Drive
Indianapolis, IN 46256-4699

Special Conditions/Considerations

1. Requests for F/S should be made by contacting the pathologist on call (schedule on OR cork board).
2. Team Leaders and Coordinators should verify the On Call schedule is accurate and up to date.
3. Both PACU RNs will be called in for all patients scheduled for a general, regional or IV Sedation anesthetic. The PACU RN be called in for patients scheduled for local anesthesia at the discretion of the OR call team with consideration to the patient's medical condition/history and admission status (i.e. OP).
4. At least two RNs will remain in the department while patients are in the department.
5. Potential functions of the PACU RN preoperatively and intraoperatively include, but are not limited to:
   - -Pick up patient preoperatively; obtain required consents and other signatures.
   - -Function as a "runner" i.e. obtains blood; deliver blood samples to lab, point of care testing
   - -Answer telephones
   - -Obtain preoperative information for upcoming cases
   - -Communicate with patient's family
   - -Remain readily accessible while patient is in the intraoperative phase of care
6. Potential functions of the OR staff post operatively:
   - -Assist with direct patient care as needed (i.e. restraining, V/S, assist with positioning)
   - -Remain in PACU I at the PACU RN's discretion
   - -Function as a "runner" i.e. obtains blood, deliver blood samples to lab
   - -Remain readily accessible until patient has been stabilized.

Community Hospital North

Indianapolis, Indiana

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

SECTION 18

Relationship with an Organ Procurement Organization (IOPO)

"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

Section 18 includes a letter from the Chief Operation Officer of Indiana Organ Procurement Organization confirming the relationship between Community North Hospital and IOPO. Also included is a copy of the Community North "Organ Donation after Circulatory Death" Policy.

IOPO

INDIANA ORGAN PROCUREMENT ORGANIZATION

June 11, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Dear Dr. VanNess,

I would like to express our sincere appreciation for the collaborative partnership with Community Hospital North in regards to the lifesaving gift of organ, tissue and eye donation.

The professionalism and enthusiasm of the Community Hospital North staff and physicians has ensured the spirit of the donation process is promoted throughout the hospital and beyond. IOPO has found Community Hospital North to be a robust advocate and partner who has consistently worked to foster a compliant and innovative approach to donation.

We thank Community's Leadership and staff for their continued support and dedication to organ and tissue donation. If you have any further questions please feel free to reach out to me directly.

Warm Regards,

Steve Johnson
Chief Operating Officer
C – 317.775.1068

iopo.org 3760 Guion Road Indianapolis, IN 46222 toll free 888 275 4676 317 685 0389 fax 317 685 1687

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved for: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 8/1/12

CLN: 3035
Page 1 of 5
EFFECTIVE: 3/26/14

TITLE: DONATION (ORGAN) AFTER CIRCULATORY DEATH

Purpose:
1. To provide the option of organ donation to patients' families who have made the decision to withdraw medical treatment/support.
2. To provide guidelines and processes to facilitate this type of organ donation, known as donation after circulatory death (DCD) or controlled non-heart beating donation.

Policy Statements
1. This policy applies to all personnel involved in the process of retrieving organs from a DCD donor.
2. A multidisciplinary team approach will be utilized to provide appropriate support for the donor family.
3. If a request is made by the family to be present at the time of death, every attempt will be made to facilitate this request
4. The family will be offered the opportunity to be with their loved one after the organ recovery surgery.
5. A DCD donation is a terminal ventilator weaning process, to be managed and guided by the end of life protocol.

General Information:
1. To date, the great majority of organ donors have been persons declared dead by brain death criteria. However, before brain death criteria were established, it was a common practice to donate organs from persons who were declared dead due to cardiac and respiratory criteria.
2. The employee may also refer to corporate clinical policy CLN#: 2055, *Organ and Tissue Donation* and nursing policy/procedure NPP#: R-9, *Care of the Patient After Death.*
3. Definitions:
   a. **Donation after circulatory death (DCD):** organ recovery from a patient pronounced dead on the basis of irreversible cessation of circulatory and respiratory function.
   b. **Non-heart beating donor:** a patient pronounced dead on the basis of irreversible cessation of circulatory and respiratory function
   c. **IOPO:** Indiana Organ Procurement Organization
      Designated requestor: Determined to be the best person to approach the family/obtain organ donation consent, based on a team huddle among the IOPO coordinator and appropriate hospital staff.

   The selection criteria for a DCD donor shall be limited to a patient:
   a. Who sustained an irreversible, severe, illness or injury no hope for survival or meaningful functional status but who does not meet brain death criteria, *and*
   b. Whose family, in consultation with the attending physician, has made the decision to withdraw medical treatment/support. This discussion and outcome are documented in the patient's hospital medical record, *and*
   c. Who is being maintained on artificial ventilation and is not expected to maintain a sustainable respiratory effort without mechanical support, *and*
   d. Whose cardiopulmonary death, in the opinion of the responsible physician, will likely occur within 60 minutes following withdrawal of hemodynamic and respiratory support, *and*
   e. Whose cause of death is known.

Equipment: None

Procedure:
   a. **Donation Discussion:** the discussion about the option of donation will take place only after the decision to remove medical treatment/support has been made. The decision to withdraw medical treatment/support must be made independently of, separately from, and predating any discussion about DCD/non-heart beating organ donation.

b. **Referral:** A referral to the Indiana Donor Alliance is to be made when it is determined that death is imminent, the Glascow Coma Scale of a vented patient is 5 or less and/or first mention of a terminal wean by physician or family (NPP R-009 Care of the Patient After Death.)

1) The consideration of, and the discussion regarding the termination of medical treatment/support occurs between the responsible physician and the family *prior* to discussion about organ donation.
2) The physician is not associated with IOPO nor affiliated with hepatic or renal transplant programs.
3) The patient meets the established DCD criteria.
4) The responsible physician, according to hospital policy, has written a "Do Not Resuscitate" order

c. **Donor Suitability Evaluation:**
1. The IOPO coordinator, with the full knowledge and assistance of the attending physician, will:
   1) Review the hospital medical record.
   2) Perform an initial physical assessment.
   3) Verify the documentation of the family discussion and decision to withdraw support.
   4) The primary nurse and physician will document the decision to withdraw support , documentation that will include the following information:
      - Date and time of discussion
      - Name of legal next-of-kin or other legally designated surrogate
      - Next-of-kin's decision
      - 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) At the direction of the IOPO coordinator, nursing staff will document in the patient's medical record the rationale for declining the patient for DCD.

e. **Consent:**
1. The IOPO coordinator and appropriate hospital staff will conduct a team huddle to determine the most suitable designated requestor.
2. The designated requestor will approach the next-of-kin to initiate the consent process.
3. As part of the consent process, it will be determined which organs may be donated.
4. In addition the following information will be shared with the family:
   1) Complete explanation of the DCD and organ recovery process, answering any questions that the family voices.
   2) Death is expected to occur in the operating room suite.
   3) Organ recovery will take place five (5) minutes after declaration of death. .The patient/family is not charged for organ evaluation, allocation, or recovery.
   4) In the event that the patient does not expire within 60 minutes after discontinuation of support, *and* does not demonstrate a significant progression towards death, the organ donation process will cease. In this situation, the family will resume financial obligations associated with terminal care.
   5) The family will be given the opportunity to see their loved one after organ recovery has been completed.
5. The next-of-kin agrees to donation, the designated requestor will:
   1) Contact the Coroner per policy #CLN 2068, Coroner's Cases, prior to obtaining consent.
   2) Complete the consent for Organ and Tissue Donation after Circulatory Death form.

3) Conduct and document a thorough medical/behavioral history interview.
   2) 3) Notify the following people and services, in collaboration with the primary nurse:
      - Community Hospitals' staff/services:
        - Responsible physician/physician of record
        - House Supervisor, who will place the patient's ICU room on

"hold" pending outcome, in the unlikely event that the patient does not expire within 60 minutes
- Operating Room – charge nurse or nurse-on-call

Staff follow EMR (EPIC) workflow for Organ DCD and Tissue Donation

- Recovery surgeon and perfusionist.
- The patient's spiritual leader of choice, and/or a hospital chaplain

4) Provide time for the family to be with the patient.
5) If the next-of-kin **declines donation**, designated requestor will:
   1) Support the family's decision.
   2) Document the decision not to donate in the patient's hospital medical record
   3) Notify the responsible physician
   4) Thank the staff for their assistance.

f. **Donor Maintenance After Consent:**
   1) The physician of record will retain full responsibility for the patient until the patient is declared dead.
   2) The physician will make clinical judgments, including the administration of medications for comfort measures, according to the end of life protocol.
   3) The use of paralytics is prohibited.
   4) When diagnostics and maintenance measures are complete the patient, accompanied by his/her primary nurse will be moved to the operating room. The Respiratory Therapist will accompany the patient and bring a ventilator for use in the OR.
   5) Once in the OR, the patient will be cared for by the primary nurse, under the direction of the physician of record, as with any other terminal wean situation.
   6) An OR nurse will be present, in compliance with OR standards of care.

g. **Withdrawal of Support (Ventilatory and Hemodynamic):**
   1) Withdrawal of support will only occur in the operating room suite.
   2) The organ recovery team will be on site and available prior to withdrawing support but will not be in the patient's OR suite during the withdrawal of support or the certification of death.
   3) The IOPO coordinator and the organ recovery team will assemble all necessary recovery equipment and prepare all perfusion/preservation solutions, to be held in wait.
   4) The OR staff will appropriately prep and drape the patient.
   5) During prepping/draping, the family will be supported by the IOPO coordinator. Family members who wish to go into the OR will be assisted to gown and glove.
   6) After draping, the family will be allowed to be with the patient and touch his/her face and hands; the family will be instructed not to touch draped and/or sterile areas.
   7) The primary RN will document withdrawal of support in the medical record
   8) During the withdrawal process, the OR nurse will remain in the OR according to OR standards of care and policies.
   9) The following withdrawal procedure will be utilized:
      - The ICU RN will administer Heparin 300 units/kg IV push if ordered by the physician.
      - The RN and/or RT will withdraw ventilator support and will discontinue all intravenous infusions excluding medications for comfort measures as ordered by the physician.
      - Cardiac monitoring and invasive blood pressure monitoring will be maintained.

h. In the unlikely event that the patient does not expire within 60 minutes, or fails to significantly progress toward death within 60 minutes:
   1) The ICU nurse in attendance will notify the Resource Coordination Administrator/House Supervisor
   2) The patient will be returned to his/her ICU room

3) If beds are in short supply, a huddle will take place between the ICU nurse, the House Supervisor and the appropriate med-surg nurse, in collaboration with the family, to determine the best placement for the patient at this time.

i. EMR documentation will continue in the current encounter. **Certification of Death:**

a. The prompt and accurate diagnosis of cardiac arrest is extremely important since recovery of organs cannot take place until the patient meets the cardiopulmonary criteria for death. (See policy #NPP R-009, *Care of the Patient After Death*)

1) Under no circumstances will an incision, for the purpose of organ recovery, be made until death is pronounced.
2) Under no circumstances will cold perfusion catheters be inserted until after death has been pronounced.
3) Under no circumstances will chest compressions be performed after the declaration of death.
   a. The physician or registered nurse declaring death will document the date and time of death in the patient's hospital medical record and a certificate of death will be completed.
   b. The family will be informed and support will be provided.
   c. Organ recovery may proceed five minutes after declaration of death.

j. **Recovery of Organs:**

1) Recovery of organs will proceed after the certification of death.
2) The recovery surgeon will be informed of the warm ischemic time, defined here as the time from pulselessness until the organs have been initially cooled and flushed.

Attachments: None

References:

1. Indiana Organ Procurement Organization, *Protocol for Donation after Circulatory Death*
2. Statement of the Institute of Medicine, *Non-Heart-Beating Organ Transplantation: Medical and Ethical Issues in Procurement*, 1997 (again in 2000)
3. *Healthcare at the Crossroads: Strategies for Narrowing the Organ Donation Gap and Protecting Patients*, Joint Commission on Accreditation of Healthcare Organizations, 2005
4. *Conditions of Participation; Conditions for Coverage: Identification of Potential Organ, Tissue, and Eye Donors – Questions and Answers*, Centers for Medicare & Medicaid Services, 2005
5. *Kennedy Institute of Ethics*, Volume 3, No. 2, 1993.
6. *Maximizing Organ Donation Opportunities Through Donation After Circulatory Death*, Critical Care Nurse, Volume 26, No. 2, April 2006.
7. *Evidence Based guideline Update: Determining Brain Death in Adults Report of the Quality Standards Subcommittee of the American College of Neurology2010*

Owned by: Network Donor Council Chairperson

Approved by:		
	Risk Management	Date: 2/4/14
	Infection Prevention	Date: 2/4/14
	Respiratory Services	Date: 3/4/14
	Patient Access	Date: 2/27/14

Approved by:	Medical Executive Committee Community Hospital East/North	Date:	2/3/14
	Medical Executive Committee Community Hospital South	Date:	5/2013
	Medical Executive Committee Community Heart and Vascular Hospital	Date:	2/4/14
Approved:	CNO Designee	Date:	3/2014
Approved:	_____ Network President and CEO	Date:	

HOSPITAL PROCUREMENT AGREEMENT

(ORGAN, TISSUE AND EYE)

This Hospital Procurement Agreement (Organ, Tissue and Eye) ("Agreement") is made this 1st day of November 2010 between Community Hospitals of Indiana, Inc. and its affiliates and subsidiaries ("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 histocompatability 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. IOPO conducts Tissue and Eye procurement services and is accredited by the American Association of Tissue Banks ("AATB"), and complies with requirements of the United States Food and Drug Administration ("FDA") in conducting Tissue and Eye procurement activities for transplantation, therapy, medical research or educational purposes;

E. The purposes of IOPO are to perform and coordinate the identification of donors, and facilitate the retrieval, procurement, preservation and transportation of Organs, Tissue and Eyes for transplantation, therapy, medical research or educational purposes, 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;

F. 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);

G. For the purposes of this agreement, Hospital is defined as the facilities operated by and for Community Health Network and are designated as Community Hospital East, Community Hospital North, Community Hospital South, the Indiana Heart Hospital and are located within the Donation Service Area of IOPO;

H. Hospital agrees to cooperate with IOPO in identifying Potential Donors in order to maximize the number of usable Organs, Tissues and Eyes 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

I. 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 therefore, 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, regardless of 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.

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, Tissues and Eyes 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, Tissues and Eyes.

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.

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) Hospital 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, Tissue and Eye Procurement. The procedures undertaken to procure donated Organs, Tissue and Eye 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, Tissue and Eye preservation, to coordinate Organ, Tissue and Eye procurement activities at Hospital, or, to serve as consultants to the Hospital physicians on the staff of Hospital, or when other qualified Organ, Tissue and Eye 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, Tissue and Eye 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, Tissue and Eye 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, Tissues and Eyes 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, Tissues and Eyes from Potential Donors; assist in the clinical management of the Donor, coordinate the procurement teams for Organ, Tissue and Eye recovery, provide technical assistance during recovery and initiate Organ, Tissue and Eye preservation and recovery;

b) provide twenty-four (24) hour availability of a Family Services Coordinator and/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, Tissue and Eye 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 and Tissue 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;

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, Tissues and Eyes 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, Tissue and Eyes, efficient placement of Organs, Tissue and Eye, and oversight of Organ, Tissue and Eye 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) obtain the vital signs of a Potential Donor and perform all pertinent tests, including blood typing using two separate samples from each Potential Donor;

l) document each Potential Donor's medical chart with all test results, including blood type, before beginning Organ or Tissue recovery;

m) 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;

n) provide qualified and trained personnel, materials, certain pharmaceuticals and equipment for recovery and preservation of Organs and Tissues after their procurement;

o) 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;

p) utilize Tissues procured at Hospital in accordance with sound medical practice and in accordance with standards recognized by the FDA and AATB;

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 and Tissue donation process, and use the analysis to affect changes in IOPO's policies and procedures to prevent the repetition of adverse events during Organ and Tissue donation;

w) 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

x) either directly or through a contract with an answering service, shall cause Organ, Tissue and Eye donation referrals to be referred to IOPO and its on-call staff.

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, Tissue and Eye 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, Tissue and Eye procurement, to follow procedures and protocols as specified by IOPO for Organ, Tissue and Eye 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 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 or Tissue Donor for which Hospital seeks reimbursement, and ensure that the family of an Organ or Tissue 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 or Tissue 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, and to limit the total facilities or other charges for the procurement of Tissues to an amount not greater than $1,200;

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, Tissue or Eye 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 or Tissue donation at Hospital; and

o) 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, Tissue or Eye recipients to entities that process or distribute Tissue or Eyes, 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

Community Hospitals of Indiana, Inc.
1500 North Ritter Avenue
Indianapolis, IN 46219
Attn: Contracts Management, Network Purchasing

IOPO:

Lynn Driver, President/CEO
Indiana Organ Procurement Organization, Inc.
3760 Guion Rd
Indianapolis, IN 46222

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 HOSPITALS OF INDIANA, INC.

By: _____
Steve Bell, Vice President, Supply Chain

INDIANA ORGAN PROCUREMENT ORGANIZATION, INC.

By: _____
Lynn Driver, President and CEO

TITLE: ORGAN AND TISSUE DONATION

Purpose:
1. To provide guidelines for health care providers for the process of organ/tissue donation and compliance with Indiana's Uniform Anatomical Gift Act IC 29-2-16-02

Policy Statements:
1. Community Hospitals are affiliated with Indiana Organ Procurement Organization (IOPO) for organ, eye and tissue donation. **All calls are to be made to the Indiana Donor Alliance (IDA), the telephone service for IOPO.** The toll free number is 1-800-356-7757.
2. No mechanical support should be withdrawn from the dying patient prior to the referral call to IDA and determination of medical suitability from IOPO.
3. The option of organ or tissue donation is to be offered to families by an IOPO representative to ensure the greatest sensitivity to matters such as timing, the circumstances of the patient's death and the beliefs and desires of those families.
4. Indiana's Uniform Anatomical Gift Act IC 29-2-16-02 provides means for a written, verifiable legal declaration of a patient's intent to donate anatomical gifts upon death. Any next of kin or guardian may not, under the law, supersede a patient's decision. Without a verifiable declaration, IOPO will follow the standard protocol of seeking family consent by offering the option of donation to the next of kin.
5. The monthly audit conducted by IOPO to identify areas of potential non-compliance will be forwarded to CHNw individuals and teams for review and action and made available to regulatory and accrediting bodies.

General Information:
Definitions:
1. Death: Individual who has sustained an irreversible cessation of all circulatory and respiratory function.
   All deaths include:
   - All cardiac deaths
   - All imminent deaths or patients who meet clinical triggers as measured by:
     - GCS of 5 or less
     - At first mention of withdraw of care
   - All still born births (where a death certificate is required)
   - DOA's (Dead on Arrival)
2. Brain Death: a sustained irreversible cessation of all functions of the entire brain, including the brain stem.
3. Imminent Death: Individual who has a condition from which a reasonable degree of medical certainty, there can be no recovery and that death will occur within a short period of time without instituting life-prolonging procedures. A patient who meets clinical triggers for organ donation.
4. Reportable Death: Deaths requiring a death certificate or fetal death certificate as required by Indiana State Department of Health. No reporting is required for abortions, miscarriages or fetal deaths less than 20 weeks gestation.
5. Organ Donation: Donation of solid organs which includes heart, lungs, liver, kidneys, pancreas and small intestines from an individual who is brain dead or meets criteria for donation after cardiac death.
6. Tissue Donation: donation of tissues, which includes heart valves, veins, arteries, tendons, ligaments, bone, fascia, skin corneas and whole eyes from an individual whose heart is no longer beating.

The hospital recognizes the importance of allowing those who wish to donate the opportunity, in the hope that solace may be provided to the grieving family by their decision to participate in improving the quality of life for others. CHNw wishes to facilitate the donation of organs, tissue and eyes in the board interest of society and those awaiting transplantation, without infringing upon a family's deeply held beliefs, values and rights.

IOPO provides information to the family of each potential organ or tissue donor regarding the desire of the patient for organ or tissue donation as designated on his/her Bureau of Motor Vehicles license or registration through www.donatelifeindiana.org. If the patient has not designated donation on his/her Bureau of Motor Vehicles license, the family has the option to donate or decline to donate organs or tissues. There will be no cost to the family of donors once the decision has been made to donate anatomical gifts.

To facilitate the opportunity for anatomical gift donation, the following processes involved with this procedure are identified:

1. CRITERIA for donation: See IOPO Manuals
2. CROSS REFERENCE:
   - Death — NPP: R-009 "Care of the Patient After Death"
     See also attached Flow Chart
   - Autopsies: CORP#: CLN-2054
   - Cardiac Death — CLN-3035, Donation organ – after cardiac death
   - Patient Rights Handbook

Procedure:

See attached flowchart

Owned by: Organ Donor Team

Approved by:

Organ Donor Team	12/2011
Risk Management	12/2011
Infection Prevention	12/2011
Chief Nursing Officer Designee	12/26/11

Approved: _____ Date:
Chief Executive Officer CHI/Chief Operations Officer CHNw

INTRODUCTION: ORGAN DONATION

Patients have the right to be organ or tissue donors upon their deaths, if they meet donor criteria. Indiana State Law and the Anatomical Gift Act require hospitals to offer the option of organ and tissue donation to all potential donors and/or families. In 1998 the Centers for Medicare and Medicaid, CMS required all health care organizations receiving Medicare reimbursement to call the local donor alliance organization for every anticipated and actual patient death. In Indiana, the donor alliance is the Indiana Donor Alliance, IDA confers with donor organizations to determine donor suitability and next steps.

Within the Community Health Network, staff members contact the IDA, who confers with out donor partners. For Community Hospital North, East, South and TIHH donor services are provided by the Indiana Organ Procurement Organization (IOPO). Community Anderson partners with Indiana Organ Procurement Organization (IOPO), Community Tissue Services (CTS) and Lions Eye Bank (LEB). The attached flowchart guides the caregiver through the process. Below are listed resources and experts.

Indianapolis

Experts/Resources

Network Donor Council Leader
317-355-5295 or 317-355-4641

Chaplains
CHE 317-355-5654
CHN 317-621-5282
CHS 317-887-7169

Ethics Committees (Call Medical Staff Office)
CHE/N 317-355-5877
CHS 317-887-7151

Indiana Donor Alliance (IDA)
1-800-356-7757

Indiana Organ Procurement Organization (IOPO)
317-685-0688 iopo.org

Corporate Clinical Policy (CLN) 2055 "Organ & Tissue Donation"

Nursing Policy/Procedure (NPP) R-09
"Care of the Patient After Death"

Donation After Cardiac Death (Organ) CLN-3035

Anderson

Experts/Resources

Nursing Administration [redacted]
Pager

Indiana Donor Alliance (IDA)
1-800-356-7757

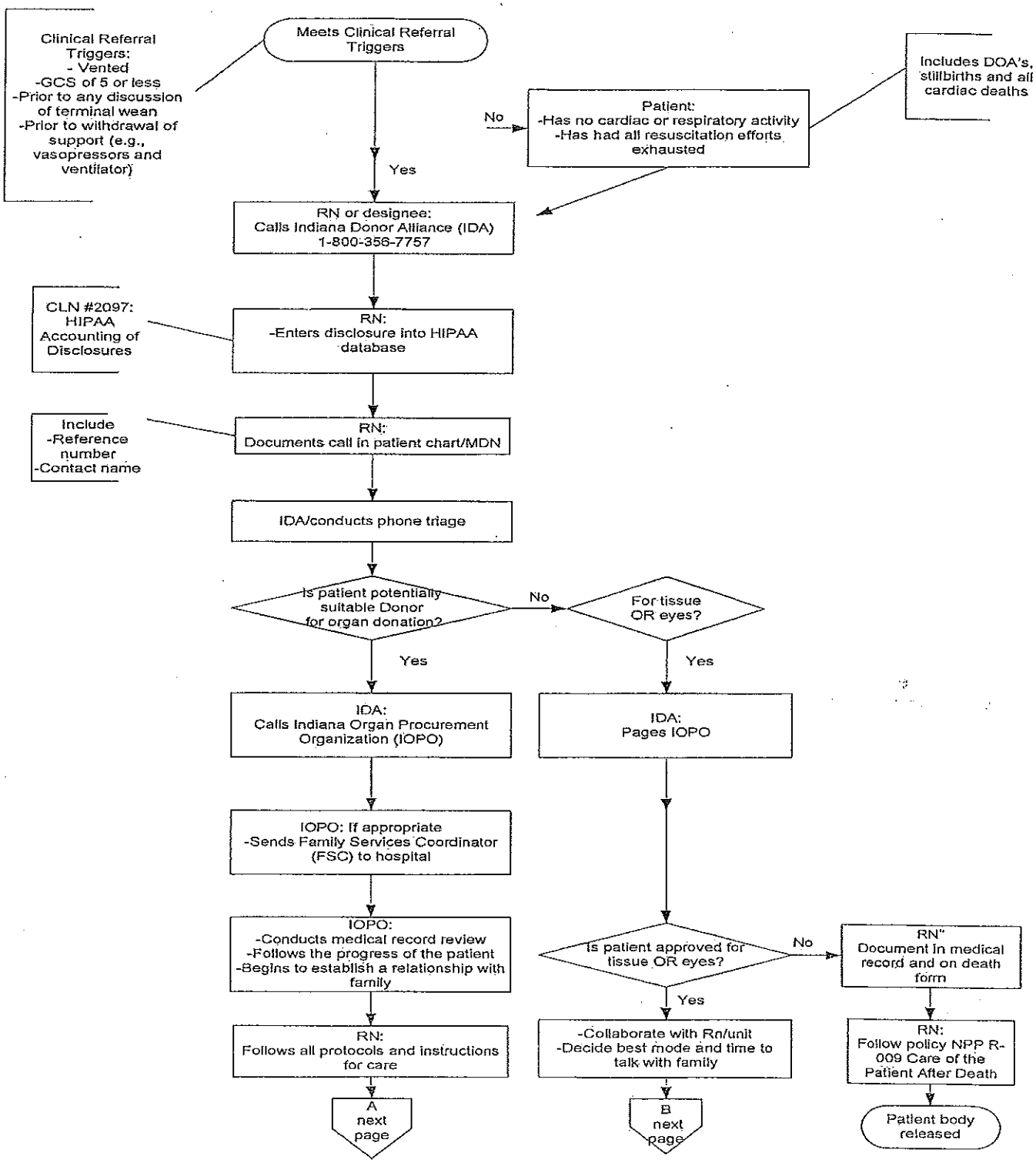
Indiana Organ Procurement Organization (IOPO) iopo.org
317-685-0688

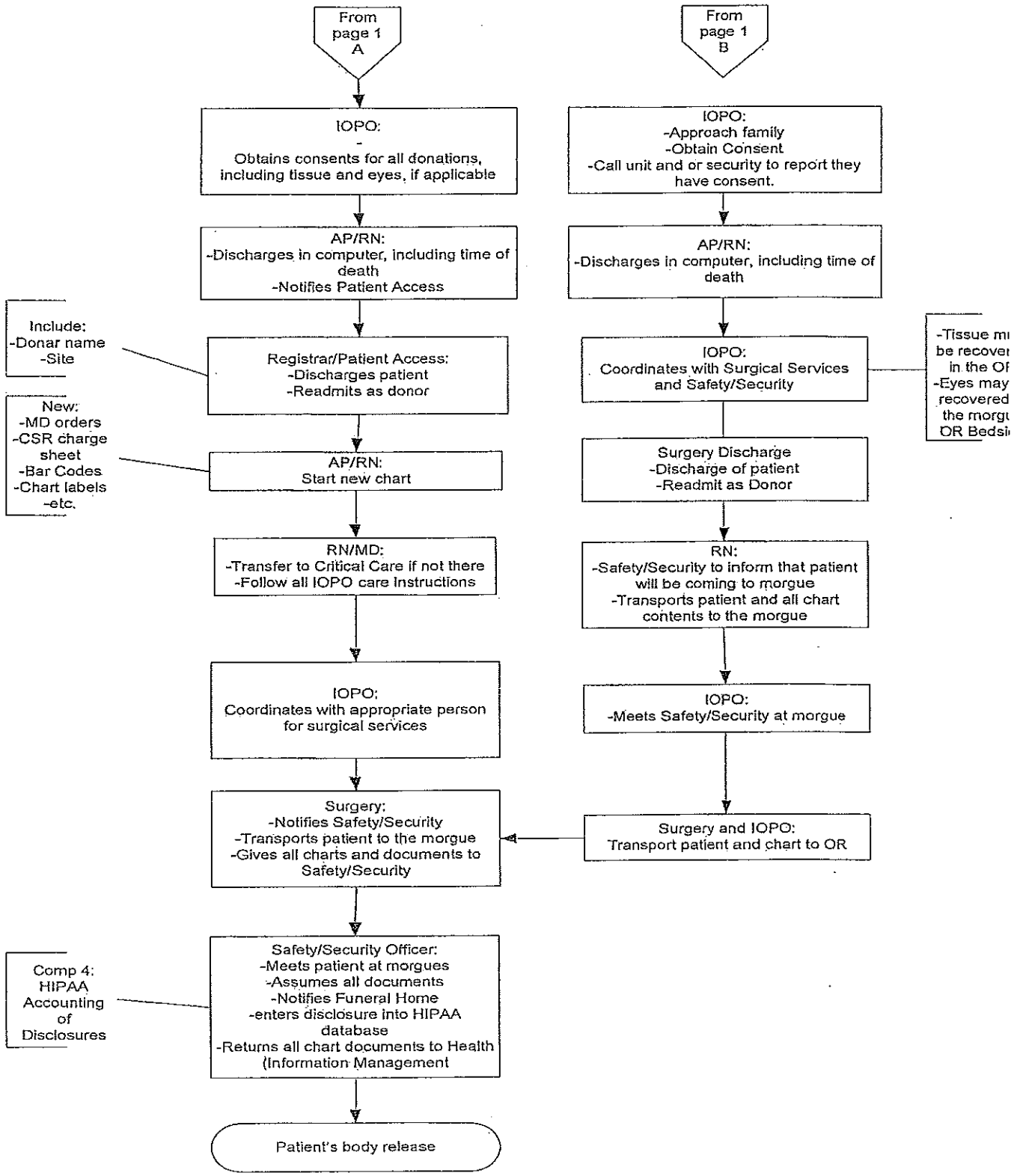
Community Tisssue Services (CTS)
communitytissue.org 1-800-984-7783

Lions Eye Bank (LEB)
lionseyebank.org 1-800-232-4384

Hospital Policy H8
"Anatomical Gift Donation"

Organ & Tissue Donation




From page 1 A
IOPO:
-
Obtains consents for all donations, including tissue and eyes, if applicable
AP/RN:
-Discharges in computer, including time of death
-Notifies Patient Access
Include:
-Donar name
-Site
Registrar/Patient Access:
-Discharges patient
-Readmits as donor
New:
-MD orders
-CSR charge sheet
-Bar Codes
-Chart labels
-etc.
AP/RN:
Start new chart
RN/MD:
-Transfer to Critical Care if not there
-Follow all IOPO care Instructions
IOPO:
Coordinates with appropriate person for surgical services
Surgery:
-Notifies Safety/Security
-Transports patient to the morgue
-Gives all charts and documents to Safety/Security
Comp 4:
HIPAA Accounting of Disclosures
Safety/Security Officer:
-Meets patient at morgues
-Assumes all documents
-Notifies Funeral Home
-enters disclosure into HIPAA database
-Returns all chart documents to Health Information Management
Patient's body release
From page 1 B
IOPO:
-Approach family
-Obtain Consent
-Call unit and or security to report they have consent.
AP/RN:
-Discharges in computer, including time of death
IOPO:
Coordinates with Surgical Services and Safety/Security
-Tissue mı be recoveı in the Of
-Eyes may recovered the morgı OR Bedsi
Surgery Discharge
-Discharge of patient
-Readmit as Donor
RN:
-Safety/Security to inform that patient will be coming to morgue
-Transports patient and all chart contents to the morgue
IOPO:
-Meets Safety/Security at morgue
Surgery and IOPO:
Transport patient and chart to OR

Community Hospital North

Indianapolis, Indiana

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

SECTION 19

Diversion Policy

"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."

NARRATIVE RESPONSE AND DISCUSSION

Included in section 19 is a letter from the Community North ED Director affirming that the hospital will not be on diversion more than 5% of the time. Also included is a copy of the Community North "Ready to Serve/Diversion" Policy and records of diversion for 2013 and to date so far for 2014.

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 2, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North'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 affirm that Community Hospital North has a "Ready to Serve/Diversion" Policy, and will not be on diversion status more than 5% of the time.

Attached you will find a record for the previous year, showing dates and length of time for each time the hospital was on diversion.

Respectfully,

Judy Hall, RN

Judy Hall, BSN, RN
Director, Emergency Department
Community Hospital North
7150 Clearvista Dr
Indianapolis, IN 46256

Community Health Network

CORPORATE CLINICAL POLICY AND PROCEDURE
Approved For: [X] CHE [X] CHN [X] CHS [X] CHVH
CANCELS: 2/9/09; 5/23/12

TITLE: READY TO SERVE/DIVERSION (AMBLUANCE DIVERSION)

Purpose:
To provide a plan for the orderly arrangement of staffing and patient placement during any situation that has the potential to cause a break in the provision of essential patient care and services. Examples include (but not limited to): a winter storm warning, internal or external disasters, Red Light Bed Alert and ambulance diversion.

Policy Statements:
1. The provision of high quality patient care is the primary focus of the Community Health Network (CHNw).
2. All departments that support patient care will maintain a roster which includes staff phone numbers, distance from the hospital and travel time to reach the hospital.
3. Staffing level that support patient care will be addressed if there is a Red Light Bed Alert, winter storm warning, code internal or external, or ambulance diversion.
4. In rare instances the need to consider diversion may be due to untoward patient volumes, high acuities, and compromised physical and/or available resources either in acute care or in the emergency department. In these situations, when there may not be sufficient patient beds and/or patient care staff to safely care for any additional patients, the delivery of ambulance patients to a facility may be temporarily diverted. The rationale of such a diversion is to allow optimal patient care, while causing the least amount of hardship to other hospitals, including other facilities in the CHNw, or to EMS providers.
5. When diversion is being considered:
   a. Only one (1) of the large metropolitan hospitals (excluding Eskenazi) will be on diversion at any one time; this includes Community Hospital East (CHE), St. Francis, St. Vincent, and Methodist.
   b. Only one (1) of the CHNw hospitals – East, North, and South –will be on diversion at any one time.
   c. In a rare instance when patient safety dictates more than one facility to divert at once negotiation and collaboration occurs between sites and leaders, eg ED Directors, Nurse Managers, and Facility President, frequently to remedy the situation. The CHE House Supervisor, after collaboration with DART is empowered to make whatever decisions are necessary to avoid diversion, this may include mandating certain patient placements or staffing patterns.
6. A recommendation for diversion is made by the Emergency Department (ED) Director after receiving data from the ED physician, the ED Patient Care Coordinator (PCC)/Charge Nurse, and the House Supervisor, The ED Director then communicates and collaborates with the Vice President (VP) of Patient Care Services or designee for that facility to finalize the decision and determine the official diversion status, ie total or critical. The Administrator on call will also be notified by the House Supervisor after hours. The cooperation of all site departments is necessary in order to implement this process. All patient care units, and all other applicable ancillary units, are expected to cooperate, negotiate in good faith, and work toward the common goal of managing patient flow and avoiding diversion.

General Information:

1. **DIVERSION** (ambulance diversion): The process of requesting EMS units to temporarily refrain from transporting incoming ambulance patients to a particular facility. Most often, diversion is due to unmanageable patient volumes, acuities, compromised physical resources or environment, Per agreement with metropolitan Indianapolis hospitals and EMS providers, there are four (4) recognized categories of diversion:
   a. Critical Care Diversion – Diversion of patients likely to require the most intense level of care and services, and likely to be admitted to critical care beds and/or monitored beds.
   b. Total Diversion – Diversion of all incoming ambulance patients. (NOTE: In the case of the following patients, the situation may be evaluated on a case-by-case basis: laboring mothers, patients in cardiac or respiratory arrest, patients in extremis, or ambulances which are in very close proximity to the hospital.)
   c. Psych Diversion – At Community Hospital North (CHN), times exist when the Behavioral Health Pavilion must divert patients. In these instances, the Medical Director and/or Executive Director for Behavioral Health are in charge of making the decision and notifying the House Supervisor at CHE to initiate the diversion.
   d. Cath Lab Diversion – Due to equipment failure in this department, diversion of patients with complaints likely to require this department's services is called and EMS units are alerted to divert those patients in order that they receive optimum care.
   e. Specific Resource Diversion – This is not an officially recognized "diversion" status in the community at large. For example, CT scanner is non-functional or both CT scanners at CHE are not functioning. Diversion of patients with complaints likely to require that resource is called and EMS units are alerted to divert those patients in order that they receive optimum care. (in CT example, stroke, and head injury). This type of diversion lasts only until the resource/issue can be resolved.
2. **BEDS/PATIENT FLOW** - Bed Alerts are a declared situation and electronic communication is sent to alert the Network.
   a. YELLOW LIGHT - approximately 91% occupancy of core beds.
   b. BLUE LIGHT - indicates the number of ready/available beds exceeds the number of available staff.
   c. RED LIGHT - nearing 100% occupancy; indicates the number of inpatients or admissions has exceeded the number of beds available.
   d. Updated Bed Aggregation numbers for each facility are maintained at CHE in the House Supervisor's office.
   e. The CHE House Supervisor is responsible for initiating the Network Alert daily.
3. **DART (Diversion Avoidance Response Team)**
   a. The DART group convenes in person and/or via telephone when census/acuity is high, and diversion is a threat. The group's goal is avoiding diversion by whatever means possible, and they are empowered to do so by Senior Leadership. A meeting of this group is requested when it is felt that diversion issues may arise soon if plans are not implemented to alleviate patient overload. NOTE: If a diversion decision is needed emergently, the ED Director in consultation with the facility VP of Patient Care Services may make that decision emergently and DART can be convened forthwith to work on solutions to end the diversion status as quickly as possible.
   b. The DART is comprised of:
      - House Supervisor
      - Emergency Department Clinical Director or designee
      - Nursing Site Leaders
      - Ancillary Site Leaders, eg., Case Management, Environmental Services
      - Facility President

- Site-specific personnel as designated by Facility President

4. EMERGENCY STAFFING PLAN - consists of:
   a. Holding essential staff over for duty on subsequent shifts
   b. And/or recruiting staff from alternative sources within the hospital network
   c. And/or requesting transportation service through Security Dispatch for staff essential to patient care and who are unable to provide their own transportation
   d. And/or providing lodging quarters, supplies, food, and compensation for staff, volunteers, and contracted service employees
   e. The hospital may provide transportation for staff needed for essential patient care and services after all efforts for self-transportation have been exhausted. When making arrangements to pick up staff, the network commits to making arrangements to take staff back home via 4-wheel drive vehicles or prepaid taxi. However, the network cannot commit to the exact time staff will be taken home. The network cannot guarantee that there will be a sufficient number of 4-wheel drive vehicles (or taxi service) available to meet the demand for pick up and return.
5. CODE INTERNAL can include, but is not limited to loss of communications, utility failure (ie electric, water, medical gas, HVAC), bioterrorist threat, chemical spill or communicable disease outbreak. A Code Internal is a situation that has potential to disrupt the normal course of business, cause damage or create casualties.
6. CODE EXTERNAL can include but is not limited to bus/plane or multiple auto accident (resulting in patient influx), release of a toxic substance, bioterrorist attack terrorist attack or incident causing multiple injuries/casualties. A Code External at one site does not mean there needs to be a Code External initiated at all sites.
7. Electronic communication devices are used to notify the network of disasters, bed alerts, etc.
8. PAY PRACTICES: refer to Community Health Network Human Resource Policy and Procedure Manual.

Procedure:

DIVERSION

1. The ED identifies that it is unable to accommodate further patient influx.
2. The charge nurse in conjunction with the ED physician contacts the ED Director/designee, who will then coordinate efforts to alleviate the situation. The Director/designee will consult with the VP of Patient Care Services and the Administrator on call as needed to get the situation relieved. If the situation is not able to be relieved, the appropriate diversion may be called at this point.
3. The department notifies the CHE House Supervisor.
4. The CHE House Supervisor pages all CHNw leadership, utilizing the network emergency alpha pagers: "Dart Meeting" with time and meeting place.
5. The DART is immediately activated, as follows (unless previously activated):
   a. There is an immediate halt on all placements of admissions, while a rapid assessment of the situation is conducted; the halt applies to, but is not limited to the following areas/departments: ED, Operating Room (OR), Post Anesthesia Care Unit (PACU), Cardiac Cath Lab, and all inpatient and short stay/daybed units.
   b. Guidelines for this rapid but thorough assessment may include, but are not limited to:
      1.) Analysis of numbers of patients throughout the facility
         b.) in ED – total and those to be admitted
         c.) in the Cath Lab – currently and slated
         d.) the OR/PACU -- currently and slated
      2.) Assessment of number of available house beds, including pending discharges and transfers

3.) Assessment of bed utilization
   a.) Are all available beds being utilized?
   b.) Are there any beds on the Pediatric or Family Rooms units? (Note: Pediatrics can take patients up to age 25 without special permission; Family Rooms can take non-infectious female patients)
   c.) Does a unit (or units) need to "flex up"?
   d.) Can patients be held in closed areas, eg, Endoscopy or Ambulatory Care?
   e.) Can stable patients be temporarily placed in inpatient unit hallways?
   f.) What closed beds can be re-opened immediately? in one hour? in four hours?
   g.) Who else can be utilized to provide patient care - non-clinical and/or administrative nurses to provide direct patient care?

4.) Movement of patients
   a.) Has a particular patient's condition been upgraded, qualifying the patient for a lower level of care?
   b.) Can patients be transferred to another CHNw facility? (eg, cardiac patients going to CHVH the next morning for cardiac catheterization.)

6. If diversion is unavoidable, the CHE House Supervisor makes the following notifications, in this order, 24/7:
   a. Notify EMS:

CHE Hancock County – Buck and Sugar Creek	Mesh Indy TRAC System [redacted]
CHN/CHVH/Behavioral Care Hamilton County	Mesh Indy TRAC System [redacted]
CHS Brown Township	Mesh Indy TRAC System [redacted]

   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers: "Diversion" with what hospital and pertinent information related to the diversion.
7. CHE House Supervisor will log diversion information in the Network Diversion Log.
8. The entire situation will be re-evaluated, not less than every two (2) hours.
9. The diversion will be deactivated as soon as possible; the CHE House Supervisor will:
   a. Notify EMS, following the above steps, see 6.a.
   b. Page all CHNw leadership, between 0600-2200, utilizing the network emergency alpha pagers stating the diversion is over.
   c. The CHE House Supervisor will log the information in the Network Diversion Log.

<u>DECLARING A YELLOW, BLUE OR RED LIGHT BED ALERT</u>

1. Each unit/department assesses bed availability for potential problems. Notify the House Supervisor at CHE via alpha-numeric pager [redacted] of potential problems.
2. The CHE House Supervisor assesses daily at 0500, 1300, 2000, and PRN the number of current inpatients at all 4 Indianapolis Community Health Network hospitals
3. The CHE House Supervisor evaluates the information from all sites to determine if a Bed Alert needs to be called. The CHE House Supervisor will assess which are the most appropriate units to place centralized staff when supply and demand do not match, eg skill mix, on-call procedures.
4. When a RED LIGHT is called, departments may be notified of the potential need to hold patients.

EMERGENCY STAFFING PLAN INITIATION:

1. Department Directors or designee determine staffing requirements for providing essential patient care and services (ie Nursing Service, Dietary, Laboratory, X-ray, and Maintenance) and initiate plans, which may include:
   a. Retain current staff.
   b. Recruit staff from alternative sources within the hospital network.
   c. Request transportation service
   d. For coordination, all nursing service units/departments communicate their individual nurse staffing status with Centralized Staffing [redacted].

TRANSPORTATION SERVICES

1. Leadership arranges employee transportation with Security [redacted] making the request as soon as possible but not more than three (3) hours prior to employee's scheduled start time.
2. Security determines transportation assignments, considering:
   a. Weather and road conditions.
   b. Employees located in close proximity to others may in some cases determine pick-up priorities.
3. Safety & Security coordinates requests for return transportation with pick up requests. Pick up requests have priority over return transportation. Return transportation is scheduled on a first come, first serve basis.
4. Transportation vehicle pool:
   a. All hospitals owned vehicles are available to the Transportation Pool
   b. Security Dispatch contacts the Director of Facilities Engineering or designee in regards to providing transportation assistance
   c. All drivers are issued a two – way radio or cellular phone.
   d. Security dispatch records driver mileage.
   e. Expenses (mileage) is recorded when non-hospital owned vehicles are used for the reimbursement of expenses under standard travel practices.
   f. Fuel reimbursement and hourly wages to hospital and non-hospital employees will be paid fuel reimbursement and hourly wages after receipts are turned into the Secretary of Safety and Security.

LODGING QUARTERS AND PROVISIONS:

1. If necessary, due to the projected length of severe, inclement weather or the projected length of the Internal Disaster, lodging quarters will be provided for employees who volunteer or are requested to stay in the hospital to staff projected vacancies.
2. Lodging will be coordinate by Environmental Services and House Supervisor.
3. Toiletries are coordinated through Materials Management.
4. Food services are coordinated by Nutrition and Food Services. The Cafeteria will be available during regularly scheduled meal periods.

Owned by: CHE House Supervisor

Approved by:		
	Infection Prevention	Date: 12/13
	Risk Management	Date: 12/13
	Safety and Security	Date: 12/13
	Emergency Department Directors	Date: 12/13
	Nutrition and Food Services	Date: 12/13
	Environmental Services	Date: 12/13

CNO Designee

Date: 12/13

Approved: _____

Network President/CEO

Date:

250

CHN DIVERSIONS (BY OCCURRENCE) 2013

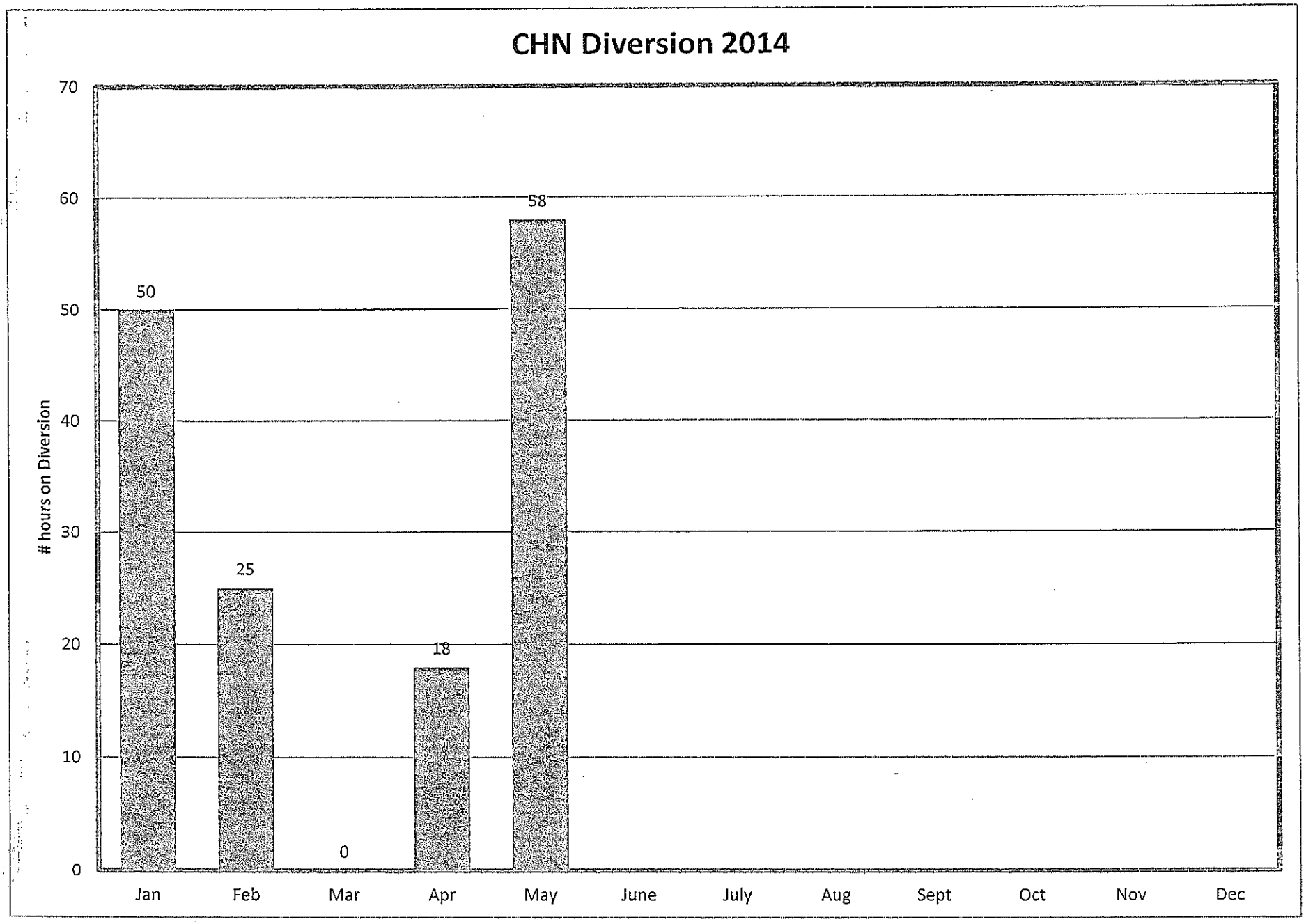
Date:	Time On	Time Off	Reason	Total Time On	
Jan. 1,2013	1:30 AM	8:30:00 AM	Tota Diversion due to total saturation of real estate and beds.	7 Hrs	
Jan. 9, 2013	7:04 PM	1/10 06:00AM	Total Diversion due to saturation of real estate and beds.	10 Hrs 56 min.	
Jan. 10, 2013	5:00 PM	10:00 PM	Total Diversion due to saturation of real estate and beds.	5 hrs	
Jan. 18, 2013	12:00 PM	1/19 @ 4:04p	Critical Care Diversion staffing and beds.	28 hrs 4 min.	Jan total 51 hrs
Feb. 15, 2013	7:00 AM	10:00 AM	ED Diversion due to Maintenance issues/sewer leak that involved ED and PCU	3 hrs	Feb total 3 hr
Apr. 9, 2013	2:30 AM	5:40 AM	Critical Care Diversion, staffing and beds.	3 hrs	Apr total 3 hr
May 13,2013	6:15PM	10:15PM	Code Internal and External. White unknown substance found at Fairbanks. Influx of patients from Fairbanks. Hospital, with already saturated beds at CHN. Unable to take anymore patients until we get the all clear and don't have to evacuate Fairbanks Hospital.	4 hrs	May total 4 hr
14-Jun-13	2:00 PM	3:10 PM	ED Diversion due to saturation, nurse call in, unable to keep up with demand.	1 hr 10 min.	Jun total 1hr.
Aug. 20, 2013	4:58 PM	8:38 PM	Critical Care Diversion due to saturation ICU/PCU full, all med surg full. Unable to take more Crit admits until we have discharges.	3 hrs 40 min.	
Aug. 22,2013	12:33PM	8:15PM	Beds saturated, not due to Staffing	7 hrs 42 min.	Aug total
Aug. 22. 2013	4:22PM	8:00PM	Beds saturated, high census	3hrs 38 min	16 hrs
Oct. 24, 2013	1:34 PM	11:15 PM	CHN Total Diversion - no beds	9 hrs 41 min	Oct. total
Oct. 25, 2013	11:15 PM	3:30 AM	Critical Care Diversion - at max capacity	4 hrs 15 min	~15 hrs
Nov. 1, 2013	12:30 PM	3:18 PM	CHN Total Diversion - no beds	2 hrs 48 min	
Nov. 1, 2013	3:18 PM	11/2 @9:30a	CHN Critical Care Diversion max capacity	18 hrs 12 min	
Nov.4, 2013	8:46 PM	11/6@12:45p	CHN Critical Care Diversion max capacity	39 hrs 59 min	
Nov. 12, 2013	8:13 AM	11/13@8:30a	CHN ICU/PCU Diversion max capacity	24 hrs 17 min	Nov total
Nov. 14, 2013	3:35 PM	11/15@5:34p	CHN Critical Care Diversion max capacity	25 hrs 59 min	~111 hrs
Dec. 4, 2013	7:03 PM	12/5@00:41a	CHN Critical Care Diversion max capacity	5 hrs 38 min	Dec total
Dec. 5, 2013	12:38PM	9:00PM	CHN Total Diversion - no beds	8 hrs 22 min	~39 hrs
Dec.12,2013	5:30 PM	12/13 8:00PM	CHN Total Diversion - no beds	26 hrs 30 min	

total
~242 hrs

247

CHN DIVERSIONS (BY OCCURRENCE) 2014

Date:	Time On	Time Off	Reason	Total Time On	
Jan. 7, 2014	5:55 PM	1/8 @ 1:16 AM	Total ED Diversion due to saturation	7 hrs 21 min	
Jan. 9, 2014	7:25 PM	1/10 @ 5:19 AM	Tota Diversion due to total saturation of real estate and beds	9 hrs 54 min	
Jan. 14, 2014	12:30 PM	1/15 @ 5:13 PM	Tota Diversion due to total saturation of real estate and beds	28 hrs 43 min	Jan Total
Jan. 22, 2014	12:30 PM	7:00 PM	Tota Diversion due to total saturation of real estate and beds	4 hrs 30 min	~50 hrs
Feb. 14, 2014	1:08 PM	2/15 @ 10:46 AM	Critial Care Diversion no available ICU beds	21 hrs 36 min	Feb Total
Feb. 18, 2014	5:43 PM	9:12 PM	Critial Care Diversion no available	3 hrs 30 min	~25 hrs
Apr. 7, 2014	2:54 PM	9:24 PM	Total ED Diversion due to saturation ED needed to decompress, uns	6 hrs 30 min.	
Apr. 30, 2014	1:20 PM	5:34 PM	Critical care diversion - No ICU or PCU beds available	4 hrs 14 min	April Total
Apr 30 2014	1734	5/1/14 12:34 AM	Total Diversion saturation of beds	7 hrs	17 hr 44 m
May 5, 2014	1900	5/6/2014 17:00	Total Diversion saturation of beds	22 hrs	
May 12, 2014	2338	5/13/2014 17:06	Critical care diversion - No ICU or PCU beds available	16 hrs 20 min	
May 14, 2014	3:45	17:15	Total Diversion- saturation of beds	15hrs 30 min	May Total
May 22, 2014	16:42	20:46	Total Diversion due to saturation of beds	4hrs 4 min	57 hr 54 m


CHN Diversion 2014
hours on Diversion
70
60
50
40
30
20
10
0
50
25
0
18
58
Jan
Feb
Mar
Apr
May
June
July
Aug
Sept
Oct
Nov
Dec

Community Hospital North

Indianapolis, Indiana

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

SECTION 20

Operational Process Performance Improvement Committee

"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

Included in section 20 are meeting charters and minutes from the Community Health Network Trauma Program Committee which has been meeting from April 29th, 2014, in addition to the Community North Trauma Performance Improvement and Patient Safety Committee which began meeting June 23rd, 2014.

COMMITTEE CHARTER

COMMITTEE NAME:	**Network Trauma Program Committee**
DATE ESTABLISHED/REVISED:	April 29, 2014
SPONSORING GROUP:	Ron (Myron) Lewis, Project Champion
PURPOSE OF THE COMMITTEE IS :	To support the provision of optimal care to the injured patient throughout the continuum of trauma care from prevention through rehabilitation, consistent with the mission of Community Health Network to obtain verification by the American College of Surgeons Committee on Trauma as a Level III Trauma Center.
The Committee Shall:	• *Trauma Program Operations*: Design process, tools, and data that will influence optimal reporting in accordance with accepted standards. • *Performance Improvement Patient Safety Program*: Review important elements of a successful PI plan, valuable audit filters, and ACS-COT expectations. • *Trauma Outreach & Education*: Best practice recommendations for trauma outreach and education, taking advantage of and sharing network resources. • *Indiana Trauma System*: Integration opportunities, and the components of a statewide trauma system. • *Trauma Program Manager*: Roles and responsibilities. • *Trauma Registry*: A trauma program cannot improve what it cannot measure, and it cannot measure without good data. • *Trauma Verification*: Planning and preparation for trauma center verification/ designation to include mock site survey visits. • *"In the Process" Application*: Assist with completion of the Indiana "In the Process" Application for Level III Trauma Center Status. • *Collaboration*: Review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to better collaborate as a team. • TBD
Decision-making Authority:	Executive Oversight Committee
Leader:	Sean Kennedy, Emergency Department Nurse Manager, Community Hospital East
Core Team:	Kristi Croddy, Trauma Program Manager, Community Hospital East Karen Hagen, Trauma Program Manager, Community Hospital North Doug McGee, Trauma Program Manager, Community Hospital Anderson Tina Sency, Trauma Program Manager, Community Howard Shawna Thomas, ED Director, Community Hospital South Broc Hinkle, ASAP Reporting Analyst, Community Health Network TBD
Meetings: Frequency,Time and Place	**Frequency:** Bi-weekly **Time:** 1400-1500 **Place:** Community Hospital North

Meeting Procedures:	• Standard meeting management template • Agenda distributed 24 hours in advance of meeting • Timekeeper and scribe will be notified via e-mail 24 hours in advance • Leader will collect agenda item suggestions via e-mail • Ground rules (established by group) will be observed • Decision-making by majority vote? Consensus? • Call-in option will always be provided • Leader will distribute minutes within one week of the meeting • TBD
Reporting:	Ron (Myron) Lewis, Project Champion
Review and Changes to Charter:	The charter shall be reviewed by the Network Trauma Program Committee annually. Recommended changes can be made to the leader or discussed as a group during the meeting.

Community Health Network
Trauma Program Manager Team
Meeting Agenda

Date/Time: *April 29, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Tina Sency	Trauma Program Manager	Community Howard
Shawna Thomas (phone)	ED Director	CHS
Sean Kennedy	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1410 Meeting Objective/Goals	As we continue the pursuit of trauma verification, organization, consistency, and teamwork are all critical to success, not just at the individual sites, but for the entire network. The purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, through an organized approach responsive to the team. The meetings will also serve to enhance communication and opportunities for collaboration.
1410-1420 Long/Short Range Planning ✓ Project Timeline	Please see the attached graphic outlining the CHNw Trauma Verification Timeline.
1420-1440 Hot Topics/Progress Updates ✓ Trauma Registry Software ✓ Trauma Education ✓ Role Hiring ✓ Transfer Agreements ✓ Successes & Barriers	*Trauma Registry Software*: The network has decided to purchase the upgraded version of ImageTrend. In the meantime and in anticipation of the May 17th deadline, please utilize the free state product to submit data. While we still need to identify how each program will capture trauma patients who do not meet predetermined activation criteria immediately upon arrival, a canned report will greatly assist our Trauma Registrars to quickly collect data. The Indiana Trauma Registry requires the NTDB data elements for each incident submitted. Thank you to Broc and Judy for your efforts thus far. As a reminder, please see the attached list. *Trauma Education*: In an effort to meet the growing needs of our network, CHN will host a TNCC course June 5-6 and June 25-26. Also, if you haven't attended already, please consider the Trauma Program Manager Course. http://www.amtrauma.org/courses/councils/trauma-coordinator-course2/index.aspx *Role Hiring*: All sites have hired a Trauma Registrar, except CHE and CHS who are in the process of interviewing. CHA is the only site with a confirmed Trauma

	Medical Director. According to the ACS, the TMD must be a general surgeon who is "active at the facility and should have some dedicated/protected time devoted to his/her role as the TMD." Again, not every trauma case requires activation. Ideally only the highest level of activations will require a 30-minute response time from the general surgeons. Depending on the facility, the volume will not be that high. The specific criteria must be agreed upon by the Trauma Medical Director. In the meantime, as a team, we will draft a tiered-trauma activation system. *Transfer Agreements*: Shawna and Ron are in the process of completing Transfer Agreements with Eskenazi, IU Health Methodist, and Riley for each location.
1440-1450 Trauma System Integration ✓ ISTCC/ITN: *May 9, 1000-1400* ✓ IPAC: *June 12, 1300-1500* ✓ Indiana Trauma Registry: *TBD*	Integration into the statewide trauma system is vital to learn, network, and advocate. Please see the upcoming opportunities, and make an effort to attend via phone or in person. If you cannot join us this Friday, I will report back to the group at our next meeting.
1450-1455 *Orange Book* Pre-Publication Review Workshop	As a team, we will review this publication, chapter by chapter, at the bi-weekly Trauma Program Manager Meetings to ensure our programs are organized, consistent, and compliant. The team was asked to review Chapter 1 in advance of our next meeting so that we can discuss relevant items together.
1455-1500 Open Forum	If you haven't already, I encourage you to print a copy of the Orange Book provided as pdf. The ACS has not yet confirmed if and when it will be in print.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 1 of *Orange Book*	Trauma Program Managers	May 13, 2014
Complete Gap Analysis Tool	Trauma Program Managers	May 13, 2014
Draft Trauma Activation Criteria	Sean Kennedy, Doug McGee, Karen Hagen	May 13, 2014

References: Indiana "In the Process" Application for Level III Trauma Center, Resources for Optimal Care of the Injured Patient

Next Meeting: May 13, 2014

Community Health Network
Trauma Program Manager Team
Meeting Agenda

Date/Time: *May 13, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Tina Sency	Trauma Program Manager	Community Howard
Amanda Gonzalez (phone)	ED Manager	CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHE
Sean Kennedy	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	Restated the purpose of these meetings is to review and work through the core concepts of building a comprehensive trauma program, enhance communication, and identify opportunities to collaborate.
1405-1415 State Trauma System Integration ✓ Indiana State Trauma Care Committee: *May 9 meeting update* ✓ Indiana Trauma Network: *May 9 meeting update* ✓ IPAC: *June 12, 1300-1500* ✓ Trauma Registry & PI Subcommittees: *TBD*	Please see the attached meeting agenda and prior meeting minutes provided at the ISTCC Meeting on May 9th. Please see the upcoming opportunities, and make an effort to attend via phone or in person. Connected the purpose and value of trauma program integration to the Criterion Deficiencies outlined in Chapter 1 of the *Orange Book*.
1415-1425 Trauma Program Status Updates ✓ Gap Analysis Tool Review ✓ Successes & Barriers	Discussed Element #1 on the *Indiana "In the Process" Application*- the Trauma Medical Director. According to the ACS-COT, "the TMD must be a board certified general surgeon and as you stated many have gone on to specialize in other areas such as cardiac, thoracic surgery, colon & rectal, bariatric, etc." These "surgeons may serve in the role of the TMD as long as they have additional expertise in trauma and care for trauma patients. Expertise define/includes trauma related CME, membership to a trauma Regional or National organization, etc al – the requirements can be found in Chapter 5 of the 2014 Resources manual." Furthermore, "the trauma surgeons on the call must meet the same requirements as the TMD above. They cannot solely perform general surgery, often time, they will do general surgery and trauma. If this is the case, there must be a backup schedule in case he/she is in the OR with a general surgery patient, when a trauma patient arrives."
1425-1440 Hot Topics/ Progress Updates ✓ Trauma Registry Software ✓ Data Submission Deadline ✓ Transfer Agreements ✓ Trauma Activation Criteria	*Trauma Registry Software*: The network has decided to purchase the upgraded version of ImageTrend. Awaiting further updates. *Submission Deadline:* In the meantime and in anticipation of the May 17th deadline to begin data

✓ Trauma Education ✓ Position Control	submission, please utilize the free state product to submit data. *Transfer Agreements*: The network is in the process of completing Transfer Agreements with Eskenazi, IU Health Methodist, and Riley for each location. No further updates. *Trauma Activation Criteria:* We reviewed and compared several local examples of trauma activation criteria, all confirmed to be based on the Field Triage Decision Scheme. As a group, we agreed consistency and standardization is imperative. As a result, the Trauma Program Manager Team is fully supportive of adopting Community Anderson's criteria for the network so that we speak the same language, operate within a similar framework, allow for accurate benchmarking, and easily communicate with EMS. *Trauma Education:* CHN will host a TNCC course June 5-6 and June 25-26. Also, if you haven't attended already, please consider the Trauma Program Manager Course and a Trauma Registrar Course. Lastly, Eskenazi Health may offer an ATLS Course in the coming months to support the need for Trauma Medical Directors and Emergency Physicians to attend prior to submission. *Position Control:* All sites have hired a Trauma Registrar, except CHE/CHS who are in the process of interviewing. CHA is the only site with a confirmed Trauma Medical Director.
1440-1450 *Orange Book* Review Workshop ✓ Pre-publication, Chapter 1	As a team, we reviewed Chapter 1 to ensure our programs understand and are in compliance. Specifically, we discussed CD 1-1, CD 1-2, and CD 1-3.
1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	Discussed the inevitable challenge of determining which patients qualify for the Trauma Registry. While ISDH and NTDB provide clear direction, it is recommended that each patient in contact with the Trauma Service is included. Doing so allows and prevents missing valuable opportunities for performance improvement, education, and injury prevention activities.
1455-1500 Open Forum	Congratulations to Community Anderson for receiving the recommendation from the Indiana State Trauma Care Committee to advance their application to the EMS Commission, which will reconvene June 20th in Gary, IN.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 2-3 of *Orange Book*	Trauma Program Managers	May 27, 2014
Complete Gap Analysis Tool, and offer to your supervisor	Trauma Program Managers	May 27, 2014
Share one success and one barrier with the group	Trauma Program Managers	May 27, 2014

Community Health Network
Network Trauma Program Team
Meeting Agenda

Date/Time: *May 27, 2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy	Trauma Program Manager	CHE
Karen Hagen	Trauma Program Manager	CHN
Doug McGee	Trauma Program Manager	CHA
Mary Schober	Trauma Registrar	CHE/CHS
Shawna Thomas (phone)	ED Manager	CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHE
Sean Kennedy	ED Manager/Facilitator	CHE
Tina Sency (Absent due to Board of Health)	Trauma Program Manager	Community Howard

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	The purpose of these meetings is to review and work through the core concepts of building a successful trauma program, to enhance communication, and to identify opportunities for collaboration.
1405-1410 Committee Charter ✓ Review, editions, and approval	The attached Committee Charter was provided in advance for review. I need your feedback before final approval. For instance, I propose we invite the Trauma Registrars to these meetings as their input, involvement, and collaboration is critical. If agreed, I need the names for each site.
1410-1420 IN "In the Process" Application Status ✓ Successes & Barriers	Each site provided an update, sharing challenges and successes. CHE and CHS plan to have Q2 2014 data submitted by June 1st.
1420-1435 Hot Topics/ Progress Updates ✓ Position Control ✓ Data Submission ✓ ImageTrend Software ✓ Transfer Agreements ✓ Letters of Commitment ✓ Blood Bank requirement ✓ Trauma Education	*Position Control:* All sites have confirmed a Trauma Registrar and Trauma Program Manager. With the exception of CHE, all sites have also hired a Trauma Medical Director. *Submission Deadline:* In the meantime and in anticipation of the data submission deadline, please utilize the free state product to submit data. *Trauma Registry Software*: Shawna explained the ImageTrend software will be purchased pending the establishment of a Trauma Admin Cost Center and final negotiations. *Transfer Agreements*: CHNw Legal Department has signed Transfer Agreements for Eskenazi and IU Health Methodis & Riley. More to follow. *Letters of Commitment*: A Letter of Commitment has been drafted for the Board of Directors to be submitted with the Indiana "In the Process" Application. To be uniform and consistent, a draft copy is attached for use as a template. *Blood Bank requirement*: According to the 2014 Resources for Optimal Care of the Injured Patient pre-publication: "The blood bank must be capable of blood typing and cross-matching (CD 11–81)." Moreover, "In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83)." However, ISDH has increased the requirement for Level III Trauma Centers, stating "A blood bank must be available 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." *Trauma Education:* Each Trauma Registrar is required to show evidence of at least 4 hours continuing education. For consideration, the American Trauma Society offers an online course. Aside from Community Howard and CHE, each Trauma Surgeon is scheduled to attend ATLS. Lastly, TNCC will be offered June 5-6 and June 25-26. *Position Control:* All sites have confirmed a Trauma Registrar and Trauma Program Manager. With the exception of CHE, all sites have also hired a Trauma Medical Director.
1435-1440 State Trauma System Integration ✓ Eskenazi collaboration	Following a meeting with the Eskenazi Trauma Program on May 19th, the group agreed future collaboration is valued, from serving as a resource to providing educational opportunities.
1440-1450 *Orange Book* Review ✓ Pre-publication, Chapters 2-3	Please let me know if you have any questions or concerns with the following requirements outlined in Chapters 2 & 3. It is critical that we all have a shared understanding and working knowledge of each criterion deficiency to be successful. • Surgical commitment is essential for a properly functioning trauma center (CD 2–2). • This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2–1). • Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2–3). • Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2–5). • For Level III trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the surgeon's presence is in compliance at least 80 percent of the time (CD 2–8). • A Level III trauma center must have continuous general surgical coverage (CD 2–12). • Well-defined transfer plans are essential (CD 2–13). • For Level I, II, III and IV trauma centers a trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. (CD 2-17). • Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).

	• Level I, II, III and IV trauma centers a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19). • Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22). • Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2–23). • For adult trauma centers annually admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals, however, must review the care of their injured children through their PIPS program (CD 2–25). • The trauma director must be involved in the development of the trauma center's bypass (diversion) protocol (CD 3–4). • The trauma surgeon must be involved in the decision regarding bypass (diversion) each time the center goes on bypass (CD 3–5). • The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2). • The trauma program must participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs (CD 3–1). • The trauma center must not be on bypass (diversion) more than 5 percent of the time (CD 3–6). • When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: Prearrange alternative destinations with transfer agreements in place, Notify other centers of divert or advisory status, Maintain a divert log, Subject all diverts and advisories to performance improvement procedures • Rigorous multidisciplinary performance improvement is essential to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage (CD 3–3).
1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	As described by the ACS-COT, "there is no precise prescription for trauma performance improvement and patient safety (TPIPS)." Still, the concept of monitoring, evaluating, and improving the performance of a trauma program is critical. Part of demonstrating a continuous process of monitoring, assessment, and management directed at improving care requires regular engagement of a multi-disciplinary team. *TPIPS & Operations Meeting* To address trauma program operational events, a multidisciplinary trauma systems/operations committee is necessary to examine trauma-related hospital operations. This committee should meet at least quarterly but may need to meet as often as monthly to review operational performance events. The committee should include representatives from all phases of care provided to injured patients to include: • Trauma Program Personnel, Trauma Surgeons,

	Physician representation from each service, Nursing Directors/Managers, Operating Room and PACU, Lab and Blood Bank, Radiology, Epic Team, EMS, Patient Access, Radiology, Pharmacy, EVS, Chaplain, Rehabilitation, Marketing, Executive Leadership *Trauma Peer Review Committee* In addition, regular Peer Review Committee Meetings are required. Chaired by the TMD, physician liaisons to the trauma program representing general surgery, emergency medicine, orthopaedics, anesthesiology, and critical care must be identified and "participate actively in the trauma PIPS program with at least 50 % attendance at multidisciplinary trauma peer review committee meetings." Level III centers with any number of emergent neurosurgical cases must also have the participation of neurosurgery on the multidisciplinary trauma peer review committee. All trauma deaths and unexpected outcomes should be reviewed to filter cases that need to undergo additional examination, review, discussion, intervention, and loop closure. The mortality and morbidity review often feeds cases to the multidisciplinary Trauma Peer Review committee. It is my recommendation that these meetings are combined for a Level III Trauma Center. For instance, the first half of these meetings may focus on TPIPS and Operations, while the second half can be reserved for select personnel in a confidential setting for Trauma Peer Review.
1455-1500 Open Forum	

Action Items	**Person Responsible**	**Deadline**
Review Chapter 3-4 of *Orange Book*	Trauma Program Managers	June 10, 2014
Inquire with ISDH whether proof of educational preparation for the TPM and Registrar is required for the "In the Process" Application.	Sean Kennedy	June 10, 2014
Share 1 success and 1 challenge with the group	Trauma Program Managers	June 10, 2014

Next Meeting: June 10, 2014

Community Health Network
Network Trauma Program Team
Meeting Minutes

Date/Time: June 10, *2014/ 1400-1500* Location: *CHN Conference Room A*

Attendance:

Name	Title	Location
Kristi Croddy (phone)	Trauma Program Manager	CHE
Lori Gill (phone)	RN	CHS
Karen Hagen (phone)	Trauma Program Manager	CHN
Judy Hall (phone)	ED Director	CHN
Mary Schober (phone)	Trauma Registrar	CHE/CHS
Broc Hinkle (phone)	ASAP Reporting Analyst	CHNw
Sean Kennedy (phone)	ED Manager/Facilitator	CHE

Agenda Items	Discussion
1400-1405 Meeting Objective/Goals	To review and work through the core concepts of building a successful trauma program, to enhance communication, and to identify opportunities for collaboration.
1405-1410 Committee Charter ✓ Review, editions, and approval	The attached Committee Charter was provided in advance for review. Trauma Registrars were added to the Charter as their input, involvement, and collaboration is critical. Pending completion of the network trauma team, the charter will be submitted as final.
1410-1420 Indiana "In the Process" Application Status ✓ Gap Analysis Tool Review ✓ Successes & Barriers	The purpose of TPIPS (Trauma Process Improvement and Patient Safety) is to address trauma program operational events, a multidisciplinary trauma systems/operations committee is necessary to examine trauma-related hospital operations. This committee should meet at least quarterly but may need to meet as often as monthly to review operational performance events. The committee should include representatives from all phases of care provided to injured patients to include: o Trauma Program Staff, Trauma Surgeons, Physician Liaison from each service, Nursing Directors/Managers, Operating Room and PACU, Lab and Blood Bank, Radiology, Epic Team, EMS, Patient Access, Radiology, Pharmacy, EVS, Chaplain, Rehabilitation, Marketing, Executive Leadership The concept of monitoring, evaluating, and improving the performance of a trauma program is critical. Part of demonstrating a continuous process of monitoring, assessment, and management directed at improving care requires regular engagement of a multi-disciplinary team and evidence of such. If you haven't already, please begin organizing regular meetings with key stakeholders. Through meeting minutes and process improvement initiatives, track evidence of establishing this foundation and your plan moving forward.
1420-1435 Hot Topics/ Progress Updates ✓ Position Control ✓ Data Submission Deadline	<u>Position Control</u>: All sites have confirmed a Trauma Registrar and Trauma Medical Director. Aside from CHN, all sites

✓ Trauma Registry Software ✓ Trauma Activation Criteria ✓ Transfer Agreements ✓ Letters of Commitment ✓ Blood Bank requirement ✓ Trauma Flow Sheet ✓ Trauma Education ✓ Tracking TMD hours	have established a permanent Trauma Program Manager. Trauma Registry Software: CHNw is in the process of purchasing ImageTrend software. Upon finalizing, full implementation of the web-based product will take approximately 30 days. Submission Deadline: In the meantime, all sites represented on the conference call plan to submit Q1 2014 data through ImageTrend by the June 30th deadline. Trauma Activation Criteria: There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program. CHE has drafted a policy to share with network Trauma Program/ED leadership, provide to the Trauma Medical Directors for review, and have presented at the next Med Exec Committee for approval. Transfer Agreements: CHNw Legal Department has signed Transfer Agreements for Eskenazi and IU Health Methodist & Riley. More to follow once finalized. Letters of Commitment: A Letter of Commitment template with CHNw letterhead was provided for the Indiana "In the Process" Application to promote uniformity. Some facilities have elected to use facility-specific letterhead. Blood Bank requirement: "In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83)." However, ISDH has increased the requirement for Level III Trauma Centers, stating "A blood bank must be available 24 hours per day with the ability to type and crossmatch blood products, with adequate amounts of PRBCs, FFP, platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients." MACL has provided CHE a Letter of Commitment, product inventory, and other materials needed for the application. Please let me know if your site has not received this information. Trauma Flow Sheet: Upon arrival and during the initial acute resuscitation phase, nursing will need to have available a hard copy form to capture patient information. Considering we do not currently have access to Trauma Narrator in Epic, the Trauma Program/ED leadership will draft a Trauma Flow Sheet to present for adoption by Emergency Departments. In the meantime, Broc Hinkle will investigate integration. Trauma Education: Each Trauma Registrar is required to show evidence of at least 4 hours continuing education. For consideration, the American Trauma Society offers an online course of which the CHE TPM and Registrar will take. Aside from Community Howard, each Trauma Surgeon is confirmed to attend ATLS. Lastly, TNCC was offered to network employees June 5-6, and is scheduled again June 25-26. Tracking TMD hours: CHE leadership has asked that the Trauma Program Manager develop a system to track and report administrative hours of the Trauma Medical Director each month, distinguishing time dedicated to chart reviews,

	policy development, meeting attendance, etc. It is recommended each site considers adopting a similar process.
1435-1440 State Trauma System Integration ✓ Indiana State Trauma Care Committee ✓ Indiana Trauma Network ✓ Indiana Prevention Advisory Council ✓ Trauma Registry & PI Subcoms	The next Indiana State Trauma Care Committee and Indiana Trauma Network meetings are schedule August 8th at the ISDH. I encourage you all to attend, but will at the very least share updates and meeting minutes with the group. The next IPAC meeting is scheduled September 10 from 1000-1200 at ISDH.
1440-1450 *Orange Book* Review Workshop ✓ Pre-publication, Chapters 4 & 5	Chapter 4: Interhospital Transfer • Direct physician-to-physician contact is essential (CD 4–1). • The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network (for example, a health maintenance organization or a preferred provider organization) or the patient's ability to pay (CD 4–2). • A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3). • Perform a PIPS review of all transfers (CD 4–3). Chapter 5: Hospital Organization and the Trauma Program • A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff (CD 5–1). • Documentation of administrative commitment is required from the governing body and the medical staff (CD 5–1) • This support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–2). • The support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–3). • The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (CD 5–4). • The TMD must be a current board-certified general surgeon (or a general surgeon eligible for certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and must participate in trauma call (CD 5-5). • The TMD must be current in Advanced Trauma Life Support® (ATLS®) (CD 5–6). • The TMD, in collaboration with the TPM, must have the authority to correct deficiencies in trauma care and exclude from trauma call the trauma team members who do not meet specified criteria (CD 5-11). • The TMD's responsibility extends far beyond the

	technical skills of surgery. The TMD must have the authority to manage all aspects of trauma care (CD 5–9). • The TMD must chair and attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. (CD 5-10) • In addition, the TMD must perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5-11). • The TMD must have the responsibility and authority to ensure compliance with the above requirements and cannot direct more than one trauma center (CD 5-12). • The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13). • Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team. • In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15). • At a minimum, the ACS requires the six criteria listed in Table 2 to be included in the highest level of activation in all trauma centers (CD 5–13). • Again, the six criteria listed in Table 2 must remain in the highest level of activation (CD 5–13). • The emergency physician may initially evaluate the limited-tier trauma patient, but the center must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission (CD 5-17). • Programs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS process (CD 5–18). • In Level III centers, injured patients may be admitted to individual surgeons, but the structure of the program must allow the trauma director to have oversight authority for the care of these patients. (CD 5-17) • There must be a method to identify the injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners (CD 5–21). • In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients (CD 5-22). • The trauma center's PIPS program must have a multidisciplinary trauma peer review committee chaired by the TMD (CD 5-25).

1450-1455 Best Practice Recommendation ✓ Programmatic, execution, or strategy	According to the ACS-COT, "Nurses and other allied health professionals should receive initial and recurrent trauma-specific education to ensure a high level of competency. Additional levels of training and certification should be available to nurses working in critical areas such as the emergency department and the trauma intensive care unit. In the Level III trauma center, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care." At a previous facility, we provided several, inexpensive opportunities for CE-approved education. For instance, rather than creating a new policy or practice guideline for each nursing unit, we met the requirements of a facility-based Trauma Education Plan by creating an educational grid reflecting each unit's expectation for trauma education. From establishment of a *Trauma Lecture Series* to monthly *Multi-disciplinary Case Conference*, we were able to support this requirement. In the future, as a network, we should consider development of a home-grown Trauma Orientation Course, providing a common framework from which we all operated. We armed staff with an understanding of the unique pathophysiology of trauma, network protocols and resources, and equipment used to care for the injured patient.
1455-1500 Open Forum	Welcome to the team Roxann Kondrat. We are excited to have you with us, and look forward to meeting you.

Action Items	**Person Responsible**	**Deadline**
Review Chapter 6 & 7 of *Orange Book*	Trauma Program Managers	June 24, 2014
Update Gap Analysis Tool	Trauma Program Managers	June 24, 2014
Share one success and one barrier with the group	Trauma Program Managers	June 24, 2014

Next Meeting: June 24, 2014

Community Health Network
Network Trauma Program Team
Meeting Agenda

Date/Time: June 13, 2014/ 1200-1300 Location: CHE Medical Staff Conference Room

Attendance:

Name	Title	Location
Sean Kennedy	ED Manager	CHE
Kristi Croddy	TPM	CHE
Judy Hall	ED Director	CHN
Karen Hagen	TPM	CHN
Shawna Thomas	ED Director	CHS
Roxann Kondrat	TPM	CHS
Mike Kuhn	ED Director	CHE
Ron Lewis (phone)	Interim President & CEO	CHRH

Agenda Items	Discussion
1200-1205 Meeting Objective/Goals	As the network pursues trauma verification, each site will be presented unique opportunities. However, an objective shared by all is the establishment of guidelines centered on care of the injured patient. A key component of an effective trauma program (and one that is required for submission with the Indiana "In the Process" Application), the development of key guidelines is necessary prior to July 8th.
1205-1220 Tiered Activation Guideline • 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.	Kristi presented a draft Trauma Tiered Activation Guideline, based upon best practice from University of Cincinnati, St. Vincent, and Community Anderson. As a group, we agreed to a tiered activation system with "Code Trauma" representing the highest level activation and "Trauma Alert" as the second level activation. Following revision of the document, Kristi will redistribute for final review prior to sharing with the Trauma Medical Directors for approval.
1220-1235 Trauma Transfer Guideline • Transfer agreements and criteria: The hospital must include as part of its application a copy of its transfer criteria specific to trauma patients, and copies of its transfer agreements. • The trauma patient transfer guideline should include, at the minimum, the criteria outlined by the ACS-COT.	As CLN-2031 already addresses the CHNw Transfer Policy, creation of an additional policy is not necessary. Instead, Shawna will provide the group a draft Trauma Transfer Guideline for review prior to sharing with the Trauma Medical Directors for approval. The guideline will meet the requirements outlined by the ACS-COT.
1235-1245 Nurse Credentialing Requirements • "Nurses and other allied health professionals should receive initial and recurrent trauma-specific education to ensure a high level of competency. Additional levels of training and certification should be available to nurses working in critical areas such as the emergency department and the trauma intensive care unit. In the Level III trauma center, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care."	Rather than creating a new policy or practice guideline for each nursing unit, the requirements of a facility-based Trauma Education Plan can be met by establishing an education grid (much like the Chest Pain or Stroke Certification Process). Sean shared a draft guideline, published by each Trauma Program and mandated for staff who care for the injured patient. Following revision of the document, Sean will redistribute for final review, presentation, and adoption.

1245-1255 Trauma Flow Sheet • Upon arrival and during the initial acute resuscitation phase, nursing will need to have available a hard copy form to document patient information.	After reviewing Trauma Flow Sheet examples from Eskenazi, St. Vincent, and Community Anderson, the group agreed to design a document based upon Eskenazi's template. Shawna will ask her Administrative Assistant to draft an example to share with the group for approval.
1255-1300 Open Forum	*Policy creation is time and resource-intensive. As a group, we agreed it is not prudent, nor necessary to engage. Instead, "operational guidelines" were proposed, assuring needed direction while allowing for flexibility. *Please submit all deliverables by Tuesday, June 17th to review and share with the Trauma Medical Directors. *The group will reconvene next week on Friday, June 20th from 1400-1500.

Committee Charter

COMMITTEE NAME:	**Community North Trauma Performance Improvement and Patient Safety, and Operations (TPIPS and Operation)**
DATE ESTABLISHED/REVISED:	June 23rd, 2014
SPONSORING GROUP:	Trauma Medical Director
PURPOSE OF THE COMMITTEE IS :	To review the performance of the trauma program, review the safety of the trauma program, provide focused education, address trauma service operational issues, and ensure that the appropriate trauma patient population is identified.
The Committee Shall:	The TPIPS and Operations 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 or Trauma Program Manager.
Decision-making Authority:	Trauma Medical Director
Leader:	Joseph Pavlik, M.D., Trauma Medical Director and Karen Hagen, Trauma Program Manager
Core Team:	Trauma Medical Director, Trauma Program Manager, Anesthesiologist, Orthopedic Surgeon, Neurosurgeon, Radiologist, ICU Medical Director, President, CNO, ED Director, ED Clinical Manager, Trauma Registrar, EMS liaison, Surgery Nursing Director/Manager, ICU Nursing Director, Quality Management Director, Radiology Administrative Director/Manager, Lab Administrative Director/Manager
Meetings: Frequency,Time and Place	**Frequency:** Monthly **Time:** TBD **Place:** Community Hospital North
Meeting Procedures:	• Standard meeting management template • Agenda distributed 24 hours in advance of meeting • Timekeeper and scribe will be notified via e-mail 24 hours in advance • Leader will collect agenda item suggestions via e-mail • Ground rules (established by group) will be observed • Decision-making by majority vote? Consensus? • Call-in option will always be provided • Leader will distribute minutes within one week of the meeting • TBD
Reporting:	Joseph Pavlik, M.D., Trauma Medical Director
Review and Changes to Charter:	The charter shall be reviewed by the Trauma Performance Improvement and Patient Safety and Operations (TPIPS and Operations) annually.

Community Hospital North
Trauma Program Operational Process Performance Committee
Meeting Minutes

June 23, 23014 1500-1600
CHN Conference Room A, Indianapolis, IN 46250

Members:						
Karen Hagen	X	Trauma Program Manager		Shannon Arrendale		Surgery Director
Sue Sandberg	X	Chief Operating Officer		Marci Jones		Surgery Director
Judy Hall	X	ED Director	X	Alberta Latham		QR/Risk Management
Shawn Tunney	X	ED Manager	X	Kathy Braniff		Lab Manager
June Rumler		ED Manager	X	Tom Young		Radiology Director
Julie Packard	X	Trauma Registrar		Joe Worley		Respiratory Therapy
Elsie Broda	X	ICU Director		Pam Hunt		Vice President Patient Services
Jonathon Bittles	X	ICU Manager		Terri Crockett		Radiology Manager

Meeting Objectives/Goals:

A. **Trauma Level III Vertification.**
B. **Application Packet near completion for submission 07/2014.**
C. **Representatives from each department is vital for success of this program.**

Committee Charter:

Established June 23, 2014
Sponsoring Group: Trauma Medical Director
Purpose of Committee: To review the performance of the trauma program, review the safety of the trauma program, provide focused education, address trauma service operational issues, and ensure that the appropriate trauma patient population is identified.
Committee Shall: The TPIPS and Operations 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 or Trauma Program Manager.
Decision-making Authority: Trauma Medical Director
Leader: Joseph Pavlik, M.D., Trauma Medical Director and Karen Hagen, Trauma Program Manager.
Core Team: Trauma Medical Director, Trauma Program Manager, Anesthesiologist, Orthopedic Surgeon, Neurosurgeon, Radiologist, ICU Medical Director, President, CNO, ED Director, ED Clinical Manager, Trauma Registrar, EMS Liaison, Surgery Nursing Director/Manager, ICU Nursing Director, Quality Management Director, Radiology Administrative Director/Manager, Lab Administrative Director/Manager.
Meetings: Monthly, Time to be Determined at Community North Hospital
Reporting: Joseph Pavlik, M.D., Trauma Medical Director
Review and Changes to Charter: The charter shall be reviewed by the Trauma Performance Improvement and Patient Safety and Operations (TPIPS and Operations) annually.

Successes: Thank you to all of those who have gathered all of the need data in order to make it possible to submit the verification application in a timely manner. After application is reviewed and approved, Community Hospital North will be eligible to receive Trauma patients beginning in August. In addition, The 1st quarter Data Submission for 2014 has been successfully entered and received into the State of Indiana Trauma Registry.

Trauma Education: TNCC and ACLS required. Department specific education and training will be assigned and is still being reviewed. There is a 1 year period in order to obtain this training and education as well as additional criteria.

Orange Book Review – Karen provided a handout, individually to each department, outlining in detail the role, responsibilities and expectations of that department, in respect to the Trauma Program and its Operations.

Next Meeting: TBD

Community Hospital North

Indianapolis, Indiana

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

SECTION 21

RN Credentialing

"Nurse credentialing requirements: Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department and ICU."

NARRATIVE RESPONSE AND DISCUSSION

Included in section 21 is a copy of the Operation Guidelines for Community Health Network in Education Requirements for the Care of Trauma Patients. There is also a copy of the Community North ED Staffing Guidelines which includes information regarding certifications for the ED Nurse.

OPERATIONAL GUIDELINE: EDUCATION REQUIREMENTS FOR THE CARE OF TRAUMA PATIENTS

OBJECTIVE:
To define continuing education requirements and expectations of nursing staff who care for the acute trauma patient.

PROCEDURE:

A. Each associate will be responsible for maintaining their continuing education requirements. Adherence to this guideline is strongly encouraged for CHNw nursing team member that cares for patients on the Trauma Service including supplemental associates (PRN).

   It is the responsibility of each nursing team member to participate in and maintain accurate documentation of their continuing education credits/units. Copies of continuing education credits/units should be given to department leadership and submitted to the appropriate credentialing organization in a timely manner.

B. Indicated verifications are recommended within 18 months from date of hire for new nursing team member or 18 months from the effective date of this guideline, unless otherwise specified. Priority will go to new nursing team members, followed by currently employed nursing team members without trauma experience, and finally, currently employed nurses with trauma experience.

C. See attached table for a complete list of education requirements by individual unit.

Staff	Requirement
Emergency Department ***Nursing staff caring for patients on the trauma service.**	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC) or Advanced Trauma Care Nursing (ATCN) o Encourage certification in the practitioner's area of specialty (i.e.- CEN, CCRN, etc.)
Operating Room	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Encourage certification in the practitioner's area of specialty.
ICU/PACU	o Completion of organizational, departmental and

	job-specific orientation. o Four contact hours trauma-related education annually. o Advanced Cardiac Life Support (ACLS) o Trauma Nurse Core Course (TNCC), Advanced Trauma Care Nursing (ATCN), or Essentials of Critical Care Orientation (ECCO) o Encourage certification in the practitioner's area of specialty.
Medical-Surgical Units/PCU	o Completion of organizational, departmental and job-specific orientation. o Four contact hours trauma-related education annually. o Encourage certification in the practitioner's area of specialty.

Community Health Network

STAFFING GUIDELINES
COMMUNITY HOSPITAL NORTH
Emergency Department

I. **Non Scheduled Occurrences**

- Staff must call into work <u>AT LEAST</u> 2 ½ hours prior to scheduled shift start time. (i.e. 0430 a.m. for 0700 a.m. shift, 12:30 p.m. for 3:00 p.m. shift, 4:30 p.m. for 7:00 p.m. shift, and 8:30 p.m. for 11:00 p.m. shift).
- Not calling in by the 2½-hour time frame will be subject to disciplinary action (see H R policy 8B).
- "No Call"/ "NO Shows" will be subject to a major disciplinary action(See HR policy 8B)
- If calling in for a scheduled shift, PTO will be used for that time. Employees are required to MEET their FTE obligation. Calling off work or trading away shifts when PTO is not available to meet your FTE is subject to disciplinary action.
- At manager's discretion consistent with the staffing needs of the dept, there may be times when a different shift may be worked to makeup the hours missed without having to use PTO.
- A nonscheduled **absence** occurrence is defined as an absence consisting of 2 hours or more in duration that is not pre-authorized or approved prior to the start of the shift. (see HR policy 10B)
- Employees returning from an illness or injury in which 3 consecutive shifts or more are missed must be evaluated and cleared by Employee Occupational Health Services prior to returning to their work assignment. (see HR policy 10B)

II. **Scheduling**

- Currently the schedule is being completed by the managers taking into consideration special requests, PTO requests, school schedules etc. Special request and PTO request are meant to be used to ask off for specific dates and duration, they are not meant to dictate what days are available to be scheduled to meet the person's FTE.
- Once the schedule is posted, staff have one week to review their schedules for errors. Staff are responsible for trading shifts to accommodate changes in their preferences, school schedules or other needs, and cannot trade into overtime.
- Schedule of Schedules is posted yearly and it gives dates when requests are due, holes will be posted for PRN minimum and when the schedule will be posted.
- Special Cause Circumstances – If you anticipate or experience a time off related event that falls outside the norms of a scheduled time off request, please contact your department leader ASAP. If your situation is viewed as a special cause event, every consideration will be made to try and accommodate the need. Failing to be timely or pro-active in such a request reduces the likelihood that consideration will be given to such a request.

III. Education

- Expiration of any Licensure, Certification, or Mandatory requirement defined by law, regulation, policy or role summary will result in the employee being removed from the schedule without pay until compliant. This includes (CPR, TB, ACLS PALS…).
- Other education that is required yearly and will be communicated over email and posted. Deadlines will be given and if staff chooses to not complete education by the deadline they will be removed from the schedule and will use PTO to meet FTE until the education is completed.
- Education time/workshops/classes must be requested off by the employee by the request off due date.
- Skills days/team days- offered two times during the year. Attendance is Mandatory. Employees that miss skills days are still responsible for the information and check offs that are required. The employee will obtain an occurrence unless on PTO or excused prior to the date by the Director.

IV. Vacations / Time Off Requests / PTO

- Every consideration will be made to approve time off requests consistent with the business and patient safety requirements of the department.
- Vacations considerations will generally be made on a first-come first-serve basis. In the event that multiple staff request time off at the same time, for the same time or similar time period; and not all requests can be granted:
  For RNs the first two requests for days / evenings/ nights will be given priority
  For non RNs the first two requests for days/ evenings/ nights will be given priority.
  For AP/ PSS the first one request for day/ evening/ night will be given priority.
- Requesting time off is a two step process; Submitting a request in Kronos AND filling name in on calendar in employee lounge. Failure to perform both steps of this process may result in PTO/RTO not being granted.
- PTO must be available in the employees bank to be given time off.
- If time is granted and by the time the vacation is scheduled there is not enough PTO to cover time off the employee must pick up available hours to meet their FTE, if unable an occurrence will be given for time off without pay.
- Minor disciplinary action will be taken if time requested off is denied and employee call in during the same requested time period. Progressive disciplinary action will be taken for any additional repeat incidents.
- Vacations or time off request can only be submitted up to one year in advance through Kronos.
- When submitting time off requests, everyone must meet their FTE status unless a PTO day or vacation has been granted.
- If time off is requested after the schedule is posted, you are expected to find your own replacement, (i.e. trading a day with another staff member). If you find someone to work for you, this cannot create scheduled overtime.

V. Holidays

- Adequate staffing must be maintained during the holidays.
- No scheduled vacations during the week of Thanksgiving, the week of Christmas and the week of New Year's. Occasional exceptions may be made depending on the individual situations.
- It will not be an option to take PTO during this time to meet ones FTE. All 8 hour holidays for a 12 hour employee will have a 4 hour shift scheduled during the pay period that contains the holiday. For example…

  -a 8 hour employee will be scheduled 8 hours on the holiday.
  -a 10 hour employee will be schedule 10 hours if they choose, or an additional 2 hour shift.
  -a 12 hour employee will be scheduled 8 hours on their holiday and an additional 4 hour shift during the pay period.
  *(Schedulers will take into consideration those that would like to do 12 hour holiday shifts if the department needs allow)

- Hospital recognized holidays are as follows:
  *Monday of Memorial Day
  *July 4th
  *Labor Day Monday
  *Thanksgiving Day
  *Christmas Day
  *New Year's Day

- Christmas Eve and New Year's eve will be a special case.
  (Employees will be scheduled to work one eve yearly)

- Holiday's will be assigned to rotation A or B.
- Holidays- if employee is absent for a holiday that is scheduled to work, employee will be scheduled an additional holiday that meets the needs of the department.

VI. Weekend Time

The assigned weekend time for day/evening shift is Saturday/Sunday. For night shift the weekend assignment is Friday/Saturday.

VII. Tardiness

- **Effective March 1, 2012, due to system changes, tardiness is considered any minute after the assigned shift.** For instance, if you clock in at 07:01 for a 7 am shift, it will be counted as a tardy.

VIII. C-Time

- C-time will be distributed on a rotating basis.

- C-time is required when it is determined to be your turn. Refusing to be on-call/take C-time can be subject to disciplinary action.
- Decision Tree: 1st Over-time
  2nd Voluntary staff
  3rd Resource Team
  4th PRN
  5th over FTE
  6th Regular staff (part time, then full time)
  (This is only a guideline and manager's discretion applies) Also See Hospital C-time policy 2D)

IX. Miscellaneous

- Posted positions. New positions will be posted in the department for one week at the nurse's station prior to posting on ecommunity.com. Employees should notify management of interest in positions in writing.
- It is the expectation that employee stays in their position for 6 months prior to requesting to change shift/ FTE.
- Employees on a set schedule will not have special requests accepted. To get a day off on a set schedule an employee must either take PTO or trade with someone else. During holiday weeks set schedules will be followed as closely as possible.

X. PRN/ CLO Staff

- See PRN Agreement
- See CLO pay for experience agreement

I have read and understand the CHN Emergency Department Scheduling Guidelines.

Employee Signature: _____

Printed Name: _____

Date: _____

Community Hospital North

Indianapolis, Indiana

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

SECTION 22

Governing Body and Medical Staff Commitment

"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."

NARRATIVE RESPONSE AND DISCUSSION

The requirement for section 22 is met with a letter of commitment written by the Chairman of the Board of Directors, as well as a letter written by the Medical Staff President for Community North Hospital affirming Community Hospital North's intent to purse Level III Trauma Verification by the American College of Surgeons within one year of this application, and to achieve ACS verification within 2 years of the granting of "in the process" status. Furthermore the letters confirm 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 two 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.

Community
Health Network

June 9, 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 Health Network Board of Directors endorses the establishment of a Level III trauma center at Community Hospital North. 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 North 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,

Mike Peterson
Chairman, Board of Directors
Community Health Network

MP/jch

Community
Hospital North

7150 Clearvista Drive
Indianapolis, IN 46256
O 317.621.6262
eCommunity.com

June 17, 2014

William C VanNess II, MD – Indiana State Health Commissioner
Indiana State Trauma Care Committee
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

Subject: Community Hospital North's Application for "in the ACS Verification Process" for Level III Trauma Center designation.

Indiana State Trauma Care Committee:

The Medical Staff Executive Committee of Community Hospital North endorses the establishment of a Level III Trauma Center at Community North Hospital. It is our understanding that approval of this application from the Indiana State Health Commissioner will allow any EMS provider to take trauma patients to this facility, thus providing Community Hospital North with the opportunity to receive the patients necessary to demonstrate a record of excellent trauma care.

Furthermore, the Medical Staff Executive Committee understands that if the hospital does not pursue verification within one year of the application and/or does not achieve ACS verification within two years of the granting of "In The ACS Verification Process" status that the hospital's "In The ACS Verification Process" status will be immediately revoked, become null and void and have no effect whatsoever.

Respectfully,

Scott Vore, MD
Medical Staff President
Community Hospital North

COMMUNITY HOSPITAL EAST & COMMUNITY HOSPITAL NORTH
MEDICAL STAFF DEPARTMENT LEADERSHIP
MARCH 1, 2012 – February 28, 2014

ANESTHESIOLOGY DEPARTMENT: **Chairman:** Scott, Vore, MD **Vice-Chairman:** Louis Bojrab, MD **QA Chairman:** Michael Caldwell, MD (for both E & N) **OB CRNA QA Chairman:** Scott Vore, MD	**OPHTHALMOLOGY DEPARTMENT:** **Chairman:** John LaTona, MD **Vice Chairman:** Uma D. Chaluvadi, MD **QA Chairman:** Uma D. Chaluvadi, MD
CARDIOLOGY DEPARTMENT: **Chairman:** Richard Hahn, MD **Vice-Chairman:** Howard Morrison, MD **QA Chairman:** Richard Hahn, MD	**ORAL/MAX SURG. & GENL DENTISTRY DEPT:** **Chairman:** Jay Cowan, DDS **Vice Chairman:** Lawrence Falender, DDS **QA Chairman:** Lawrence Falender, DDS
CARDIOVASCULAR SURGERY: **Chairman:** Russell Dilley, MD **Vice-Chairman:** Robert Shoemaker, MD **QA Chairman:** Russell Dilley, MD	**ORTHOPAEDIC DEPARTMENT:** **Chairman:** Brett R. Fink, MD **Vice-Chairman:** Jon Sieber, MD **QA Chairman:** Jon Sieber, MD
EMERGENCY DEPARTMENT: **Chairman:** Kevin Trappe, MD **Vice-Chairman:** Christian Haag Burke, MD **QA Chairman:** David Cheng, MD	**OTOLARYNGOLOGY DEPARTMENT:** **Chairman:** Michael Myers, M.D. **Vice-Chairman:** Richard Biggerstaff, MD **QA Chairman:** Richard Biggerstaff, MD
FAMILY PRACTICE DEPARTMENT: **Chairman:** James Metzler, MD **Vice-Chairman:** Barbara Davis, MD **QA Chairman:** Barbara Davis, MD	**PATHOLOGY DEPARTMENT:** **Chairman:** John Oscherwitz, MD **Vice- Chairman:** C. Norman Hurwitz, MD **QA Chairman:** C. Norman Hurwitz, MD
GENERAL SURGERY DEPARTMENT: **Chairman:** Jon Jansen, MD **Vice-Chairman:** Shekar Narayanan, MD **QA Chairman:** Shekar Narayanan, MD	**PEDIATRIC DEPARTMENT:** **Chairman:** Kristen Wielandt Gollnick, MD **Vice-Chairman:** Shannon M. Tighe, MD **QA Chairman:** Jennifer S. Layman, MD
INTERNAL MEDICINE DEPARTMENT: *(1yr term)* **Chairman** - Joseph Kwakye, MD **Vice - Chairman** - Joseph Henderson, MD **QA Chairman** - Joseph Henderson, MD	**PLASTIC SURGERY DEPARTMENT:** **Chairman:** Michael Stalnecker, MD **Vice-Chairman:** Howard Dash, MD **QA Chairman:** Howard Dash, MD
MED/SURG NEUROLOGY DEPARTMENT: **Chairman:** Douglas Strobel, MD **Vice-Chairman:** Jill Donaldson, MD **QA Chairman:** Jill Donaldson, MD	**PSYCHIATRY DEPARTMENT:** **Chairman:** Syed Khan, MD **Vice-Chairman:** Jason Ehret, MD **QA Chairman:** D. Mark Snelson, MD
OB/GYN DEPARTMENT: **Chairman:** Michelle Murphy, MD **Vice-Chairman:** Sarah Kerlin, MD **QA Chairman:** Sarah Kerlin, MD	**RADIOLOGY DEPARTMENT:** **Chairman:** David Kurlander, MD **Vice-Chairman:** Scott Childress, MD **QA Chairman:** David Kurlander, MD
ONCOLOGY DEPARTMENT: **Chairman:** Jack Wei, MD **Vice-Chairman:** Anuj Agarwala, MD **QA Chairman:** Jack Wei, MD	**UROLOGY DEPARTMENT:** **Chairman:** David Scheidler, MD **Vice-Chairman:** Richard Bennett, III, MD **QA Chairman:** David Stuhldreher, MD

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 Health Network and its subsidiaries Community Hospital South, Inc. and Community Howard Regional Health, Inc. (hereinafter "Hospital"). Eskenazi Health and Hospital 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 Health Network, Inc. and its subsidiaries operate acute care hospitals commonly referred to as Community Hospital East, Community Hospital North, Community Hospital South and Community Howard Regional Health (collective "Hospital")

Eskenazi Health and Hospital 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 Hospital therefore agree as follows:

1. ***Term.*** This Agreement shall become effective beginning June 1, 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 Hospital 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 Hospital requests for patient transfers to Eskenazi Health shall be referred to the Bed Control Coordinator/House Supervisor. Prior to moving the patient, Hospital 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 Hospital.*** The request for transfer of a patient from Eskenazi Health to Hospital shall be initiated by the patient's attending physician. Any

authorized member of Hospital's medical staff may authorize a transfer if Hospital has an appropriate bed available and is not on diversion. Prior to moving the patient, Eskenazi Health must receive confirmation from Hospital that it can accept the patient, and there must be direct communication between the referring and receiving physician. Patients shall be delivered to Hospital'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

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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.*** Hospital 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 Hospital, its agents, employees or invitees from any cause arising out of or relating to Hospital's performance under this Agreement. Any obligation of Hospital to save and hold Eskenazi Health harmless is limited in substance by statutes designed to protect and limit the exposure and liability of Hospital as a qualified health care provider under the Indiana Medical Malpractice Act.

Eskenazi Health shall save, indemnify, and hold Hospital 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 Hospital 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:

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

Indianapolis, IN 46202

COMMUNITY HEALTH NETWORK:
Community Hospital Network
Attn: Legal Department
7330 Shadeland Station
Indianapolis, IN 46256

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 Hospital 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 MD

Lisa Harris, CEO and Medical Director

Date: 6/24/14

COMMUNITY HEALTH NETWORK

By: [signature]

Title: CHIEF PHYSICIAN EXEC.

Date: 6/27/14