El Camino Health

AGENDA
REGULAR MEETING OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS

Wednesday, December 11, 2024 – 5:30 pm
El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

THE PUBLIC IS INVITED TO JOIN THE OPEN SESSION PORTION OF THE MEETING LIVE AT THE ADDRESS ABOVE OR VIA TELECONFERENCE AT: **1-669-900-9128, MEETING CODE: 918 6381 3131# No participant code. Just press #.**

To watch the meeting, please visit: ECH Board Meeting Link

Please note that the livestream is for **meeting viewing only** and there is a slight delay; to provide public comment, please use the phone number listed above.

NOTE: If there are technical problems or disruptions that prevent remote public participation, the Chair has the discretion to continue the meeting without remote public participation options, provided that no Board member is participating in the meeting via teleconference.

A copy of the agenda for the Regular Board Meeting will be posted and distributed at least seventy-two (72) hours prior to the meeting. In observance of the Americans with Disabilities Act, please notify us at **(650) 988-3218** prior to the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations.

	AGENDA ITEM	PRESENTED BY	ACTION	ESTIMATED TIMES
1	**CALL TO ORDER AND ROLL CALL**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
2	**CONSIDER APPROVAL FOR AB 2449 REQUESTS**	Bob Rebitzer, Board Chair	Possible Motion	**5:30 pm**
3	**POTENTIAL CONFLICT OF INTEREST DISCLOSURES**	Bob Rebitzer, Board Chair	Information	**5:30 pm**
4	**PUBLIC COMMUNICATION** a. **Oral Comments** *This opportunity is provided for people to address the Board on any matter within the subject matter jurisdiction of the Board that is not on this agenda. Speakers are limited to three (3) minutes each.* b. **Written Public Comments** *Comments may be submitted by mail to the El Camino Hospital Board of Directors at 2500 Grant Avenue, Mountain View, CA 94040. Written comments will be distributed to the Board as quickly as possible. Please note it may take up to 24 hours for documents to be posted on the agenda.*	Bob Rebitzer, Board Chair	Information	**5:30 pm**
5	**ECHB SPOTLIGHT RECOGNITION – Purchasing and Supply Chain Departments** Adopt Resolution 2024-03	Bob Rebitzer, Board Chair	**Motion Required**	**5:30 – 5:35**
6	**FORMATION OF ECHB BYLAWS REVIEW AD HOC COMMITTEE** Adopt Resolution 2024-04	Bob Rebitzer, Board Chair	**Motion Required**	**5:35 – 5:40**
7	**CONSENT CALENDAR ITEMS:** a. Approve Hospital Board Open Session Minutes (11/20/2024) b. Approve Report for Environment of Care as Reviewed and Recommended for Approval by the Quality Committee c. Approve Conflict of Interest Policy as Reviewed and Recommended for Approval by the Compliance and Audit Committee and Governance Committee	Bob Rebitzer, Board Chair	**Motion Required**	**5:40 – 5:45**

	d. Approve Policies, Plans and Scopes of Service as Reviewed and Recommended for Approval by the Medical Executive Committee e. Receive Period 4 Financials f. Receive CEO Report			
8	**RECESS TO CLOSED SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**5:45 – 5:46**
9	**HEALTHCARE LANDSCAPE POST ELECTION – FEDERAL AND STATE** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets.*	Lanhee Chen, Director	Discussion	**5:46 – 6:10**
	BREAK FOR DINNER			
10	**STRATEGY UPDATE** *Health and Safety Code Section 32106(b) for a report and discussion involving healthcare facility trade secrets.*	Dan Woods, CEO	Discussion	**6:30 – 7:00**
11	**WOMEN'S HOSPITAL EXPANSION PROJECT – CONSTRUCTION CONTRACT AND FUNDING MATTER** *Gov't Code Section 54956.9(d)(2) - Conference with legal counsel – pending or threatened litigation*	Ken King, CASO Theresa Fuentes, CLO	**Motion Required**	**7:00 – 7:10**
12	**PHYSICIAN SERVICES AGREEMENTS** - Enterprise Gastroenterology ED and Inpatient Call Panel Services - Enterprise Neurodiagnostic Coverage Services *Health and Safety Code Section 32106(b) – for a report and discussion involving healthcare facility trade secrets.*	Mark Adams, MD, CMO	Discussion	**7:10 – 7:15**
13	**APPROVE CREDENTIALING AND PRIVILEGING REPORT** *Health & Safety Code Section 32155 and Gov't Code Section 54957 Report regarding personnel performance for a report of the Medical Staff; deliberations concerning reports on Medical Staff quality assurance matters:*	Mark Adams, MD, CMO	**Motion Required**	**7:15 – 7:20**
14	**APPROVE MINUTES OF THE CLOSED SESSION OF THE EL CAMINO HOSPITAL BOARD OF DIRECTORS** - Minutes of the Closed Session of the ECHB Meeting (11/20/2024) *Report involving Gov't Code Section 54957.2 for closed session minutes.*	Bob Rebitzer, Board Chair	**Motion Required**	**7:20 – 7:25**
15	**EXECUTIVE SESSION**	Bob Rebitzer, Board Chair	Discussion	**7:25 – 7:30**
16	**RECONVENE TO OPEN SESSION**	Bob Rebitzer, Board Chair	**Motion Required**	**7:30 – 7:31**
17	**CLOSED SESSION REPORT OUT** To report any required disclosures regarding permissible actions taken during Closed Session.	Gabe Fernandez, Governance Services Coordinator	Information	**7:31 – 7:32**
18	**APPROVE PHYSICIAN SERVICES AGREEMENTS** - Enterprise Gastroenterology ED and Inpatient Call Panel Services - Enterprise Neurodiagnostic Coverage Services	Bob Rebitzer, Board Chair	**Motion Required**	**7:32 -7:34**
19	**ADJOURNMENT**	Bob Rebitzer, Board Chair	**Motion Required**	**7:35**

	APPENDIX **Dessert Reception to Follow**			

NEXT MEETINGS: February 5, 2024; March 12, 2025 (Joint Board-Committee meeting); April 16, 2025; May 14, 2025; June 18, 2025

El Camino Hospital Board

RESOLUTION 2024 – 03

RESOLUTION OF THE BOARD OF DIRECTORS OF EL CAMINO HOSPITAL REGARDING RECOGNITION OF SERVICE AND SUPPORT

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

WHEREAS, the Board honors and recognizes the Purchasing and Supply Chain team for their excellent work amidst current nationwide challenges in obtaining IV fluids.

WHEREAS, the Board acknowledges the Purchasing and Supply Chain team for proactively ensuring the safety and well-being of our patients, allowing us to continue delivering the highest level of care.

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

THE LEADERSHIP GROUP AND TEAM MEMBERS OF THE PURCHASING AND SUPPLY CHAIN DEPARTMENTS

FOR YOUR DEDICATION TO EL CAMINO HOSPITAL AND COMMITMENT TO ALWAYS PUTTING PATIENTS FIRST.

IN WITNESS THEREOF, I have hereunto set my hand this **11TH DAY OF DECEMBER 2024.**

EL CAMINO HOSPITAL BOARD OF DIRECTORS:

Lanhee J. Chen, JD, PhD
Julia E. Miller
Carol A. Somersille, MD, FACOG
John L. Zoglin

Wayne Doiguchi
Jack Po, MD, PhD
George O. Ting, MD

Peter C. Fung, MD, MBA
Bob Rebitzer
Don Watters

John Zoglin
Secretary/Treasurer
El Camino Hospital Board of Directors

EL CAMINO HOSPITAL BOARD OF DIRECTORS
RESOLUTION 2024-04
APPOINTMENT OF SPECIAL ADVISORY COMMITTEE FOR
LIMITED PURPOSE AND LIMITED DURATION

WHEREAS, the Board of Directors has determined it is necessary to carefully review and update the El Camino Hospital Bylaws; and

WHEREAS, such work can be undertaken by a special advisory committee with l assistance from legal counsel for presentation to and consideration by the Board of Directors at a future meeting.

NOW, THEREFORE, BE IT RESOLVED, that a temporary advisory special committee ("The Bylaws Review Ad Hoc Committee"), consisting of ________ [**up to 4]** members is hereby established pursuant to Article VII, Section 7.6 of the Bylaws of the El Camino Hospital, to carefully review and consider updates to the El Camino Hospital Bylaws;

BE IT FURTHER RESOLVED that the members of the Bylaws Review Ad Hoc Committee shall determine the time, place, date, and frequency of such committee meetings;

BE IT FURTHER RESOLVED, that ________________ is appointed as Chair of the Bylaws Review Ad Hoc Committee;

BE IT FURTHER RESOLVED, that _____________, shall also serve as a member[s] of the committee having been appointed by the El Camino Hospital Board of Directors.

DULY PASSED AND ADOPTED at a regular meeting held on December 11, 2024, by the following votes:

AYES:

NOES:

ABSENT:

ABSTAIN:

____
John Zoglin, Secretary
El Camino Hospital Board of Directors

DRAFT

El Camino Health

Minutes of the Open Session of the El Camino Hospital Board of Directors
Wednesday, November 20, 2024

El Camino Hospital | 2500 Grant Road Mountain View, CA 94040 | Sobrato Boardroom 1

Board Members Present
Bob Rebitzer, Chair
Jack Po, MD, Ph.D., Vice-Chair (arrived at 5:46 p.m.)
John Zoglin, Secretary/Treasurer
Wayne Doiguchi
Peter Fung, MD, MBA
Julia E. Miller
Carol A. Somersille, MD
George O. Ting, MD
Don Watters

Board Members Absent
Lanhee Chen, JD, PhD

Others Present
Dan Woods, CEO
Carlos Bohorquez, CFO
Shahab Dadjou, President, ECHMN
Theresa Fuentes, CLO
Mark Klein, CC&MO
Tracey Lewis Taylor, COO
Shreyas Mallur, MD, CQO
Deb Muro, CIO
Cheryl Reinking, CNO
Diane Wigglesworth, VP, Compliance
Andreu Reall, VP of Strategy

Others Present (cont.)
Steve Xanthopoulos, MD, MV Chief of Staff
Tracy Fowler, Director, Governance Services
Gabriel Fernandez, Governance Services Coordinator
Brian Richards, Information Technology

***via teleconference*

Agenda Item	Comments/Discussion	Approvals/ Action
1. CALL TO ORDER/ ROLL CALL	The open session meeting of the Board of Directors of El Camino Hospital (the "Board") was called to order at 5:31 p.m. by Chair Bob Rebitzer. Roll call was taken, and a quorum was present. Director Chen was absent, and Director Po was absent at roll call.	***The meeting was called to order at 5:31 p.m.***
2. AB-2449 – REMOTE PARTICIPATION	No AB-2449 requests were received by the members of the Board.	
3. POTENTIAL CONFLICT OF INTEREST DISCLOSURES	Chair Rebitzer asked the Board if any member had a conflict of interest with any items on the agenda. No conflicts were noted.	
4. PUBLIC COMMUNICATION	Chair Rebitzer invited the members of the public to address the Board. No members of the public were present. A written comment from Karen Lemes was included in the packet and shared with the public and the Board.	
5. RECEIVE VERBAL MEDICAL STAFF REPORT	Dr. Xanthopoulos provided a verbal report. He shared an example of collaboration between the medical staff and administration during the IV fluid shortage, highlighting their successful efforts to continue providing care despite supply limitations. Discussion also included updates on staffing, recruitment, retention, and wellness initiatives. The report ended with Dr. Xanthopoulos expressing satisfaction with the team's work, the Board's support, and the potential for future challenges. Dr. Xanthopoulos then exited the meeting at 5:42.	
6. QUALITY FOCUSED REVIEW - FY2025 Q1 STEEEP Update - HAC Review	Chair Rebitzer asked for comments or questions on the STEEEP dashboard. Discussion focused on the patient questions for social determinants of health, sepsis management, radiology turnaround time, and mortality index improvement. Dr. Mallur responded to all comments and questions with details and Dr. Somersille provided some extra context on the questions about medical records. During the review of Hospital-Acquired Infections	

DRAFT

	(HAI) discussion focused on both progress and general trends. The materials highlighted the work that staff had done and continues to do to ensure continuing positive outcomes for our patients. Director Ting praised the team's transparency and direct responses during the discussion.	
7. RECESS TO CLOSED SESSION	**Motion:** To recess to closed session at 6:01 p.m. **Movant**: Fung **Second**: Miller **Ayes**: Doiguchi, Fung, Miller, Po, Rebitzer, Somersille, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen **Recused**: None	***Recessed to closed session at 6:01 p.m.***
8. AGENDA ITEM 16: CLOSED SESSION REPORT OUT	Chair Rebitzer reconvened the open session at 7:36 p.m., and Agenda Items 8-14 were addressed in the closed session. Mr. Fernandez reported that during the closed session, the Credentialing and Privileges Report and Closed Session Minutes were approved by a unanimous vote of all Directors present.	***Reconvened Open Session at 7:36 p.m.***
9. AGENDA ITEM 17: CONSENT CALENDAR	Chair Rebitzer asked if any member of the Board wished to remove an item from the consent calendar for discussion. No items were removed. **Motion:** To approve the consent calendar. **Movant**: Fung **Second**: Miller **Ayes**: Doiguchi, Fung, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Somersille **Recused**: None	***Consent Calendar was approved.*** *Prior Open Minutes*
10. AGENDA ITEM 18: CEO REPORT	Mr. Woods provided the CEO report summarizing key organizational updates including the success of our nurses at recent Magnet conference, the Foundation's fundraising efforts, and the organization's performance in the Healthcare Anchor Network. Director Ting congratulated Ms. Muro on her recent 2024 ORBIE award.	
11. AGENDA ITEM 19: BOARD ANNOUNCEMENTS	There were no announcements from the Board.	
12. AGENDA ITEM 21: ADJOURNMENT	**Motion:** To adjourn at 7:41 p.m. **Movant**: Po **Second**: Doiguchi	***Meeting adjourned at 7:41 p.m.***

DRAFT

DRAFT

	Ayes: Doiguchi, Fung, Miller, Po, Rebitzer, Ting, Watters, Zoglin **Noes**: None **Abstentions**: None **Absent**: Chen, Somersille **Recused**: None	

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

____

John Zoglin, Secretary/Treasurer

Prepared by: Tracy Fowler, Director, Governance Services
Reviewed by Legal: Theresa Fuentes, Chief Legal Officer

DRAFT

El Camino Health

EL CAMINO HOSPITAL
BOARD MEETING COVER MEMO

To: El Camino Hospital Board of Directors
From: Ken King, CAO
Date: December 11, 2024
Subject: FY-24 Annual Report – Evaluation of the Environment of Care & Emergency Management

Recommendation(s): Approve the Annual Report, Evaluation of the Environment of Care & Emergency Management for FY-24 as reviewed and approved by the Quality Committee.

Summary:

1. Situation: The management of the environment of care, the safety program with all its elements and the emergency management plan produced mixed results in FY-25. Results include:

   a) **Employee Safety:** The rate of OSHA Recordable Injuries decreased 15% in 2023, however they have increased 35% in 2024. The lost work time rate decreased 50% in 2023 but increased 17% in 2024. These rate increases from the prior year were due to an increased number of Patient Lift Transfer Injuries, and Bloodborne Pathogen Exposures. Note however that we remain below national and state rates for OSHA Recordable Injuries. Improvement strategies have been implemented to reduce the number of injuries.

   b) **Security:** The number of OSHA reportable Workplace Violence incidents increased 45% from the prior year with a total of 45 WPV incidents in 2024. The increase was due in large part to confused and dementia patients acting out.

   c) **Hazardous Materials:** There were no Reportable Hazardous Material Incidents or Wastewater Discharge violations.

   d) **Fire Safety:** There were no Fire Incidents at any El Camino Health facilities in FY-24.

   e) **Medical Equipment:** The planned maintenance for high-risk medical equipment was maintained at 99.42% completion rates, a slight improvement over the prior year.

   f) **Utilities: There** were four PG&E electrical power outages during FY-24, two in Los Gatos and two in Mountain View. This is a reduction from the prior year which had nine power outages. All emergency power systems functioned as designed and there were no negative outcomes.

   g) **Emergency Management:** There were no incidents during FY-24 that prompted the activation of the Command Center and activation of the HICS (Hospital Incident Command System) protocols. However, the organization did participate in three Drills which provided valuable training and education for our emergency preparedness.

1. Authority: Policy requires Quality Committee Approval of this report annually to maintain compliance with Joint Commission and CMS standards.

2. Background: This report is a required element for compliance with Joint Commission and CMS standards annually.

3. Assessment: The individuals, work groups and committees that oversee the elements of the Environment of Care, Life Safety and Emergency Management continue to follow a continuous cycle of improvement.

4. Other Reviews: This annual evaluation has been reviewed and approved by the Central Safety Committee and the Emergency Management Committed.

5. Outcomes: This annual report has been utilized to prepare updated management plans for each work group and committee for FY-24.

List of Attachments:

1. (IN APPENDIX) Full Report – FY-24 Evaluation of the Environment of Care & Emergency Management

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Theresa Fuentes, Chief Legal Officer
Diane Wigglesworth, VP of Compliance
Date: December 11, 2024
Subject: Proposed Modifications to Conflict of Interest Policy and Disclosure Process

Purpose:

In order to increase awareness of personal financial disclosures that should be reported, modifications were made to the current Conflict of Interest (COI) policy, Conflict of Interest Annual Disclosure Statement, training, and the review process. These changes were discussed with the Compliance and Audit Committee and the Governance committee, and their recommendations were incorporated into the policy.

Summary:

To comply with hospital policy, state and federal regulations, and for hospital to maintain federal tax emption status, disclosures regarding personal financial interest or gain by members of the Board of Directors, Board Committee members, Management, Physician Leaders and all ECH employees should be reported. All individuals subject to the policy, regardless of whether or not they are required to file an annual disclosure statement, are expected to immediately self-report situations that could be perceived as a potential conflict of interest in order to appropriately review and resolve prior to ECH entering into business decisions or transactions. Revisions have been made to the COI policy and Conflict of Interest Annual Disclosure Statement to encourage more accurate, transparent, and timely reporting or identification of potential conflicts.

1. Situation: It was identified that some individuals may have been unaware or unclear of the types of personal financial disclosures that should be reported annually or failed to notify of a specific disclosure in order to recuse themselves before evaluating business decisions. To add some clarity, revisions were made to the policy and Conflict of Interest Annual Disclosure Statement to encourage transparent reporting. We will also be implementing training upon hire/onboarding, and annually for those required to complete the annual disclosure statement.

2. Background: Conflict of Interest Annual Disclosure Statements are provided annually to Board members, Board Committee members, management, and physician leaders and certain ECH employees. In most cases the Conflict of Interest Annual Disclosure Statements are returned indicating no conflicts to report. It became clear that some individuals involved in a material role with respect to business decisions were unclear that all personal financial interests should be reported regardless of a perception that a conflict exists. Other than sharing the hospital policy, no focused training had been provided to individuals asked to complete the Conflict of Interest Annual Disclosure Statement. Additionally, disclosures completed by individuals were maintained by the

Compliance department but were not available in a shared location for review by the Chief Legal Officer and Executive Leadership to assist in proper management of a personal financial interest disclosure or review prior to development of Board and Committee agendas or ECH entering into particular transactions or arrangements.

3. Assessment: Reviewing the COI process was identified as a FY 25 Compliance and Audit Committee goal. Compliance and Legal reviewed information individuals provided on previous Conflict of Interest Annual Disclosure Statements and identified some opportunities to improve the process. Compliance and Legal also became aware of some conflicts of interest that should have been identified and mitigated in advance. The following recommendations are made:

- Revisions to the policy and Conflict of Interest Annual Disclosure Statement to help clarify what information should be disclosed.

- Updating the policy to clarify several key process points:

  - COI training will be provided to all staff upon hire/onboarding and annually for those who are required to complete the Conflict of Interest Annual Disclosure Statement. We are working toward implementing an electronic training module so that the COI training immediately precedes electronic completion of the Conflict of Interest Annual Disclosure Statement. COI training will also be incorporated into the board and committee member onboarding process.

  - Interests must be disclosed **both** annually on the Conflict of Interest Annual Disclosure Statement **and** in specific situations if the person is involved in a transaction or arrangement or decision where the person has an actual or perceived personal interest.

  - Process for identifying potential conflicts of interest, including:
    - Review of Board and Committee member disclosures by Compliance, Legal, and Executive Leadership prior to board and committee meetings, and in advance of approval for transactions/arrangements.
    - Potential COI will be discussed with individuals impacted and resolved per escalation process discussed in policy. For Board and Committee members, this involves initial discussion with Compliance Officer or Chief Legal Officer, and if needed, convening an Ad Hoc Interests Committee consisting of Chair of Board and Chair of Committee (if Committee member involved), Chief Executive Officer, Corporate Compliance Officer, and Chief Legal Officer. Outside entities may be consulted for assistance in reviewing conflicts. If necessary, matter will be reviewed by full Board.

- Implementing regular reporting to the Compliance and Audit Committee overall compliance with the COI policy.

- Implementing advance reviews of matters schedule to be considered by the Board and Committees with potential conflicts identified on disclosure statements.

- Developing online training modules that can be circulated when annual disclosures are requested.

- Creating a shared drive for review by Compliance, Legal, and Executive Leadership of disclosure statements in advance of board and committee meetings and transactions/arrangements.

4. Other Reviews: These revisions were reviewed by the Compliance and Audit Committee and Governance Committee and recommended for approval by the Board.

5. Outcomes: Compliance and Legal will take steps to roll out formal training and education to all individuals subject to the policy and will review information submitted.

List of Attachments:

1. (IN APPENDIX) Conflict of Interest Policy – redline
2. (IN APPENDIX) FY 25 Conflict of Interest Annual Disclosure Statement - new

El Camino Health

BOARD OF DIRECTORS
Documents for Review
December 11, 2024

Department	Document Name	Origination	Last Reviewed	Revised?	Doc Type	Committee
New Business						
Imaging Services	A07d1. Radiation Safety – Personnel and Medical Staff Monitoring and Dosimetry	3-1993	11-10-21	Revised	Policy	• Radiation Safety • Dept of Surgery • ePolicy • MEC • Board > Publish
CPWC	A07d2. Cardio Pulmonary Wellness Center: Scope of Service	5-1995	11-10-21	None	Scope of Svc	• Dept Dir • ePolicy • MEC • Board > Publish
Clinical Education	A07d3.Scope of Service – Clinical Education Department	8-2015	9-22-21	None	Scope of Svc	• Dept Dir • ePolicy • MEC • Board > Publish
Patient Care Services	A07d4. End of Life Option Act Policy	5-2016	9-22-21	Revised	Policy	• ePolicy • MEC • Board > Publish
Medical Staff	A07d5.Medical Staff Code of Conduct and Professional Behavior	10-2008	8-12-20	Revised	Policy	• Med Staff Leadership • ePolicy • MEC • Board > Publish
Patient Experience	A07d6. Patient Rights	4-1998	6-23-21	Revised	Policy	• ePolicy • MEC • Board > Publish
Pharmacy	A07d7. MERP – Medication Error Reduction Plan	11-2020	12-6-23	None	Plan	• Med Safety • P&T • ePolicy • MEC • Board > Publish
Nursing	A07d8. Plan for Provision of Nursing Care	10-2015	12-8-21	Revised	Plan	• ePolicy • MEC • Board > Publish
Human Resources	A07d9. Equal Employment Opportunity/Disability and Reasonable Accommodation	9-1994	2-10-21	Revised	Policy	• HR Leaders | CHRO • ePolicy • MEC • Board > Publish

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
BOARD MEETING MEMO

To: El Camino Hospital Board of Directors
From: Carlos A. Bohorquez, Chief Financial Officer
Date: December 11, 2024
Subject: Financials: FY2025 – Period 4 & YTD (as of 10/31/2024) - Consent Calendar

Purpose:

To provide the Board an update on financial results for FY2025 Period 4 (October 2024) & YTD.

Executive Summary – Period 4 (October 2024):

Patient activity / volumes remain consistent across the enterprise.

- **Average Daily Census:** 316 is 14 / 4.5% favorable to budget and 11 / 3.7% higher than the same period last year.
- **Adjusted Discharges:** 3,854 are 151 / 4.1% favorable to budget and 75 / 2.0% higher than the same period last year.
- **Emergency Room Visits:** 6,645 are 93 / 1.4% favorable to budget and 122 / 1.8% lower than the same period last fiscal year.
- **Outpatient Visits / Procedures:** 13,768 are 1,665 / 13.8% favorable to budget and 2,133 / 18.3% higher than the same period last fiscal year.

Financial performance for Period 4 was favorable to budget. This is attributed to higher than budgeted patient volume in the areas of inpatient / outpatient surgeries, ER visits and NICU days.

Total Operating Revenue ($):	$147.5M is $9.4M / 6.8% favorable to budget and $14.9M / 11.2% higher than the same period last fiscal year.
Operating EBIDA ($):	$21.8M is $1.2M / 5.7% favorable to budget and consistent with the same period last fiscal year.
Net Income ($):	$0.7M is $16.6M / 95.7% unfavorable to budget and $11.9M / 94.2% lower than the same period last fiscal year.
Operating Margin (%):	9.1% (actual) vs. 8.8% (budget)
Operating EBIDA Margin (%):	14.8% (actual) vs. 14.9% (budget)
Net Days in A/R (days):	53.3 days are favorable to budget by 0.7 days / 1.2% and 1.1 days / 2.0% better than the same period last year.

Executive Summary – YTD FY2025 (as of 10/31/2024):

With the exception of outpatient visits / procedures and surgeries, year-over-year patient activity is flat.

- **Average Daily Census:** 303 is 2 / 0.6% unfavorable to budget and 1 / 0.2% lower than the same period last year.
- **Adjusted Discharges:** 14,711 are 41 / 0.3% favorable to budget and 31 / 0.2% lower than the same period last year.
- **Emergency Room Visits:** 26,159 are 156 / 0.6% unfavorable to budget and 4 / 0.0% lower than the same period last fiscal year.

- **Outpatient Visits / Procedures:** 50,328 are 3,624 / 7.8% favorable to budget and 5,441 / 12.1% higher than the same period last fiscal year.

Total Operating Revenue ($):	$555.3M is $12.7M / 2.3% favorable to budget and $55.2M / 11.0% higher than the same period last fiscal year.
Operating EBIDA ($):	$78.0M is $0.5M / 0.6% favorable to budget and $2.1M / 2.8% higher than the same period last fiscal year.
Net Income ($):	$102.5M is $40.1M / 64.1.4% favorable to budget and $79.6M / 347.0% higher than the same period last fiscal year. Favorable net income is attributed to stable financial performance and unrealized gains on investment portfolio.
Operating Margin (%):	8.0% (actual) vs. 7.9% (budget)
Operating EBIDA Margin (%):	14.0% (actual) vs. 14.3% (budget)

Recommendation:

- Recommend approval of FY2025 – Period 4 & YTD financials

List of Attachments:

- Financial Report: FY2025 Period 4

Suggested Finance Committee Discussion Questions:

- None

El Camino Health

Summary of Financial Operations

Fiscal Year 2025 – Period 4

7/1/2024 to 10/31/2024

Operational / Financial Results: Period 4 – October 2024 (as of 10/31/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	316	302	14	4.5%	304	11	3.7%	---	---	---	---
	Adjusted Discharges	3,854	3,703	151	4.1%	3,779	75	2.0%	---	---	---	---
	OP Visits / OP Procedural Cases	13,768	12,103	1,665	13.8%	11,635	2,133	18.3%	---	---	---	---
	Percent Government (%)	57.0%	58.0%	(0.9%)	(1.6%)	58.0%	(1.0%)	(1.7%)	---	---	---	---
	Gross Charges ($)	626,470	574,197	52,272	9.1%	533,435	93,035	17.4%	---	---	---	---
Operations	Cost Per CMI AD	20,095	20,032	63	0.3%	18,301	1,794	9.8%	---	---	---	---
	Net Days in A/R	53.3	54.0	(0.7)	(1.2%)	54.4	(1.1)	(2.0%)	48.1	49.7	47.5	
Financial Performance	Net Patient Revenue ($)	141,741	132,891	8,850	6.7%	126,800	14,941	11.8%	297,558	564,735	---	
	Total Operating Revenue ($)	147,507	138,097	9,410	6.8%	132,646	14,862	11.2%	389,498	610,593	268,739	
	Operating Margin ($)	**13,475**	**12,085**	**1,390**	11.5%	**13,516**	**(41)**	(0.3%)	**7,400**	**11,601**	**8,331**	
	Operating EBIDA ($)	**21,782**	**20,611**	**1,171**	5.7%	**21,725**	**57**	0.3%	**26,400**	**39,689**	**22,574**	
	Net Income ($)	738	17,309	(16,571)	(95.7%)	12,630	(11,892)	(94.2%)	19,085	20,150	15,049	
	Operating Margin (%)	**9.1%**	**8.8%**	**0.4%**	4.4%	**10.2%**	**(1.1%)**	(10.3%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**14.8%**	**14.9%**	**(0.2%)**	(1.1%)	**16.4%**	**(1.6%)**	(9.8%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	269	275	(6)	(2.1%)	255	15	5.7%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 2024. Dollar amounts have been adjusted to reflect monthly averages.

Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

Operational / Financial Results: YTD FY2025 (as of 10/31/2024)

($ thousands)		Current Year	Budget	Variance to Budget	Performance to Budget	Prior Year	Year over Year change	YoY % Change	Moody's 'Aa3'	S&P 'AA'	Fitch 'AA'	Performance to Rating Agency Medians
Activity / Volume	ADC	303	305	(2)	(0.6%)	304	(1)	(0.2%)	---	---	---	---
	Adjusted Discharges	14,711	14,670	41	0.3%	14,742	(31)	(0.2%)	---	---	---	---
	OP Visits / OP Procedural Cases	50,328	46,704	3,624	7.8%	44,887	5,441	12.1%	---	---	---	---
	Percent Government (%)	57.9%	58.4%	(0.5%)	(0.9%)	58.7%	(0.8%)	(1.4%)	---	---	---	---
	Gross Charges ($)	2,366,813	2,263,141	103,671	4.6%	2,073,697	293,116	14.1%	---	---	---	---
Operations	Cost Per CMI AD	20,164	20,032	132	0.7%	18,413	1,751	9.5%	---	---	---	---
	Net Days in A/R	53.3	54.0	(0.7)	(1.2%)	54.4	(1.1)	(2.0%)	48.1	48.1	47.5	
Financial Performance	Net Patient Revenue ($)	532,527	521,633	10,894	2.1%	478,879	53,648	11.2%	1,190,233	2,258,938	---	
	Total Operating Revenue ($)	555,281	542,537	12,744	2.3%	500,119	55,162	11.0%	1,557,992	2,442,371	3,224,864	
	Operating Margin ($)	**44,404**	**42,642**	**1,762**	4.1%	**42,868**	**1,536**	3.6%	**29,602**	**46,405**	**99,971**	
	Operating EBIDA ($)	**77,956**	**77,491**	**465**	0.6%	**75,814**	**2,143**	2.8%	**105,601**	**158,754**	**270,889**	
	Net Income ($)	102,547	62,482	40,065	64.1%	22,943	79,604	347.0%	76,342	139,215	180,592	
	Operating Margin (%)	**8.0%**	**7.9%**	**0.1%**	1.7%	**8.6%**	**(0.6%)**	(6.7%)	**1.9%**	**1.9%**	**3.1%**	
	Operating EBIDA (%)	**14.0%**	**14.3%**	**(0.2%)**	(1.7%)	**15.2%**	**(1.1%)**	(7.4%)	**6.8%**	**6.5%**	**8.4%**	
	DCOH (days)	269	275	(6)	(2.1%)	255	15	5.7%	258	304	311	

Moody's Medians: Not-for-profit and public healthcare annual report; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
S&P Medians: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; August 2024. Dollar amounts have been adjusted to reflect monthly averages.
Fitch Ratings: U.S. Not-For-Profit Health Care Stand-Alone Hospital Median Financial Ratios; July 2024. Dollar amounts have been adjusted to reflect monthly averages.

Notes: DCOH total includes cash, short-term and long-term investments.
OP Visits / Procedural Cases includes Covid Vaccinations / Testing.

Unfavorable Variance < 3.49%
Unfavorable Variance 3.50% - 6.49%
Unfavorable Variance > 6.50%

Consolidated Balance Sheet (as of 10/31/2024)

($000s)

ASSETS		
		Audited
CURRENT ASSETS	**October 31, 2024**	**June 30, 2024**
Cash	229,159	202,980
Short Term Investments	85,021	100,316
Patient Accounts Receivable, net	234,238	211,960
Other Accounts and Notes Receivable	19,632	25,065
Intercompany Receivables	18,440	17,770
Inventories and Prepaids	52,002	55,556
Total Current Assets	**638,492**	**613,647**
BOARD DESIGNATED ASSETS		
Foundation Board Designated	24,395	23,309
Plant & Equipment Fund	532,760	503,081
Women's Hospital Expansion	44,160	31,740
Operational Reserve Fund	210,693	210,693
Community Benefit Fund	17,568	17,561
Workers Compensation Reserve Fund	12,811	12,811
Postretirement Health/Life Reserve Fund	23,009	22,737
PTO Liability Fund	40,726	37,646
Malpractice Reserve Fund	1,713	1,713
Catastrophic Reserves Fund	36,948	33,030
Total Board Designated Assets	**944,784**	**894,322**
FUNDS HELD BY TRUSTEE	**18**	**18**
LONG TERM INVESTMENTS	**700,062**	**665,759**
CHARITABLE GIFT ANNUITY INVESTMENTS	**985**	**965**
INVESTMENTS IN AFFILIATES	**37,923**	**36,663**
PROPERTY AND EQUIPMENT		
Fixed Assets at Cost	2,019,954	2,016,992
Less: Accumulated Depreciation	(902,432)	(874,767)
Construction in Progress	191,903	173,449
Property, Plant & Equipment - Net	**1,309,425**	**1,315,675**
DEFERRED OUTFLOWS	46,637	41,550
RESTRICTED ASSETS	50,478	32,166
OTHER ASSETS	192,926	195,447
TOTAL ASSETS	**3,921,729**	**3,796,213**

LIABILITIES AND FUND BALANCE		
		Audited
CURRENT LIABILITIES	**October 31, 2024**	**June 30, 2024**
Accounts Payable	59,442	71,017
Salaries and Related Liabilities	55,049	35,693
Accrued PTO	41,818	38,634
Worker's Comp Reserve	2,300	2,300
Third Party Settlements	12,881	13,419
Intercompany Payables	14,562	13,907
Malpractice Reserves	1,830	1,830
Bonds Payable - Current	10,820	10,820
Bond Interest Payable	4,604	7,673
Other Liabilities	15,167	12,261
Total Current Liabilities	**218,472**	**207,554**
LONG TERM LIABILITIES		
Post Retirement Benefits	23,009	22,737
Worker's Comp Reserve	12,811	12,811
Other L/T Obligation (Asbestos)	28,665	27,707
Bond Payable	440,601	441,105
Total Long Term Liabilities	**505,086**	**504,360**
DEFERRED REVENUE-UNRESTRICTED	**471**	**1,038**
DEFERRED INFLOW OF RESOURCES	**84,484**	**92,261**
FUND BALANCE/CAPITAL ACCOUNTS		
Unrestricted	2,837,288	2,731,120
Minority Interest	(1,159)	(1,114)
Board Designated	224,482	216,378
Restricted	52,606	44,616
Total Fund Bal & Capital Accts	**3,113,216**	**2,991,001**
TOTAL LIABILITIES AND FUND BALANCE	**3,921,729**	**3,796,213**

El Camino Health

El Camino Health

EL CAMINO HOSPITAL BOARD OF DIRECTORS
CEO REPORT I DECEMBER 11, 2024

MARKETING + COMMUNICATION: In August, El Camino Health launched its new brand campaign known as the "Strong" campaign built on the message: **"Our Strength. Your Health."** Research data suggests our market audience sees this as an authentic community identity for El Camino Health and a brand/advertising/communications-media message built around this should have high resonance. The story of our campaign is primarily told through real patient stories sharing their positive experiences about our high level of care and caring.

Our first data measurement validations confirms that the "Strong" message is indeed resonating. El Camino Health improved in both aided and unaided brand recall over previous campaigns. Overall ECH brand campaign recall among the market audience reached a 3-year high. In addition, correct brand linkages to ECH ads reached a high point. We expect brand campaign performance measurement to improve further as the campaign continues in the coming months.

In media and communications measurement, El Camino improved its competitive cumulative "share of voice" in the market through October 2024.

INFORMATION SERVICES: ECH received the **Most Wired Level 9 designation for both acute and ambulatory care for 2024**, recognizing our transformative digital health practices across eight key segments (infrastructure, security, supply chain, data management, interoperability, patient engagement, innovation and clinical quality). **The AngelEye camera system** was implemented in Mountain View NICU to provide the ability for parents to visually see their infants from anywhere. **Commure Strongline**, our staff safety platform, now provides protection beyond the Los Gatos internal building into the outside hospital areas, including parking structure.

COMMUNITY PARTNERSHIPS: **The annual Community Benefit grant application** is scheduled to go live on December 11, 2024, and applications will be due by February 28, 2025. As in previous years, there will be Community Benefit Grant Application Information Sessions held via Zoom where our Community Partnerships staff will provide an overview of the Community Health Needs Assessment, Implementation Strategy Report and Community Benefit Plan, and FY2026 application highlights and logistics.

FOUNDATION: In October, El Camino Health Foundation secured $3,490,811 in donations. This brings **total funds raised through period 4 to $9,516,100, which is 124 percent of goal for FY2025**. The Foundation hosted a stewardship reception for major donors and El Camino Health leaders that was attended by more than 100 guests, including hospital board members, executives, service line directors, and key physician leaders.

CORPORATE HEALTH: Concern is expanding choices for employees to receive help, including **a new online program** focused on helping couples solve relationship problems.

AUXILIARY: The Auxiliary donated **3,767 volunteer hours** for the month of October

El Camino Health

Fiscal Year 2024 Evaluation of the Environment of Care And Emergency Management

Prepared by:

Matt Scannell
Director, Safety and Security

Bryan Plett
Manager, Environmental Health and Safety

Created: 09/13/2024

Table of Contents

Program Overview 1

Executive Summary 2

EC 1.0 – Safety Management 11

EC 2.0 – Security Management 19

EC 3.0 – Hazardous Materials and Waste Management 25

EC 4.0 – Fire Safety Management 28

EC 5.0 – Medical Equipment Management 30

EC 6.0 – Utilities Management 32

EM – Emergency Management 34

Program Overview

The Joint Commission standards provide the framework for the Safety Program for managing the Environment of Care Program, Emergency Management and Life Safety at El Camino Hospital. These programs meet the State of California requirements for an Injury and Illness Prevention Program (IIPP). It is the goal of the organization to provide a safe and effective environment of care for all patients, employees, volunteers, visitors, contractors, students and physicians. This goal is achieved through a multi-disciplinary approach to the management of each of the environment of care disciplines and support from hospital leadership.

The Central Safety Committee and Hospital Safety Officer (Ken King Chief Administrative Officer) develop, implement and monitor the Safety Management Program for the Environment of Care, Emergency Management and Life Safety Management. Reporting is completed as required for Joint Commission compliance.

The Central Safety Committee membership consists of the chairperson of each Work Group, and representatives from Infection Prevention, Clinical Effectiveness, Radiation Safety, the Clinical Laboratory, Employee Wellness and Health Services (EWHS), Nursing, Safety / Security and Human Resources.

Work Groups are established for each of the Environment of Care sections. They have the responsibility to develop, implement and monitor effectiveness of the management plan for their respective discipline. The status of each section is reviewed at the Central Safety Committee meeting and reported on the Safety Trends. The Safety Officer is accountable for the implementation of the responsibilities of the Central Safety Committee.

The Emergency Management Committee has the responsibility to develop, implement and monitor the effectiveness of the emergency preparedness program of El Camino Health. The committee provides a summary of activities to the Central Safety Committee on a quarterly basis.

The Central Safety Committee chairperson is responsible for establishing performance improvement standards to objectively measure the effectiveness of the Safety Program for the Environment of Care.

The following annual review analyzes the scope, performance, and effectiveness of the Safety Program and provides a balanced summary of the program performance during fiscal year 2024. Strengths are noted and deficiencies are evaluated to set goals for the next year or longer-term.

Executive Summary

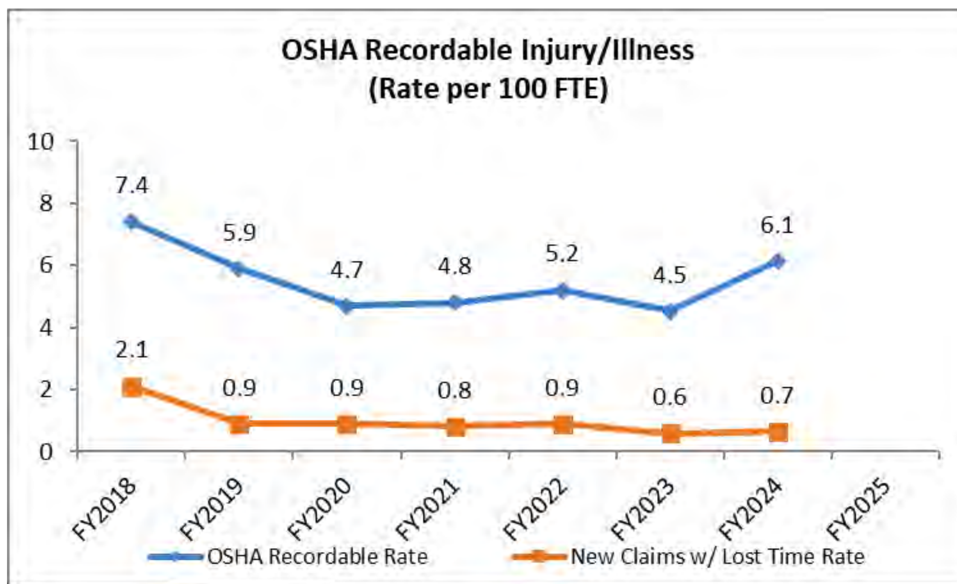
Safety Management

Performance

Performance indicators offer the opportunity to objectively assess areas of focus and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-24. This includes data from both the Mountain View and Los Gatos campuses.

A. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 Full Time Equivalent employees (FTE) increased in FY-24 to 6.1 as compared to 4.5 in FY-23. The change is directly attributed to increased reporting of injuries that do not involve lost time or job transfer. Contributing factors to this increase include increased departmental outreach and education at Tier 1 daily huddles, Management Team attention and sharing lessons learned at Enterprise Huddle, and a focus on prompt employee reporting of bloodborne pathogen exposures (needlesticks). The rate of claims with lost time per 100 FTE remained stable at 0.7 in FY-24 compared to 0.6 in FY-23. Thus, although overall injury reporting is increasing, injuries of consequence remain stable.



Analysis

- In FY-24, the rate of OSHA recordable injuries increased 35% compared to FY-23 and the loss time rate observed an absolute increase of 0.1 (17%) compared to FY-23.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were strains and sprains at 42%, blood and bodily fluid exposures (e.g. needlesticks and other exposures to blood) at 20%, and contusions

at 16%. There were 12 (6%) Cal/OSHA recordable injuries due to patient agitation (e.g. workplace violence).

- In FY-24 bloodborne pathogen exposures due to needle sticks increased to 28 injuries compared to 22 injuries in FY-23. An overall increase in exposures such as splashes of bodily fluids to the eyes was noted. Improvement strategies will be explained in the bloodborne pathogen exposures section below.

Effectiveness

Key indicators were identified to establish goals for FY-24 with opportunities to improve Safety Management within the Environment of Care.

FY 24 Goals

1) Reduce employee bloodborne pathogen exposures.

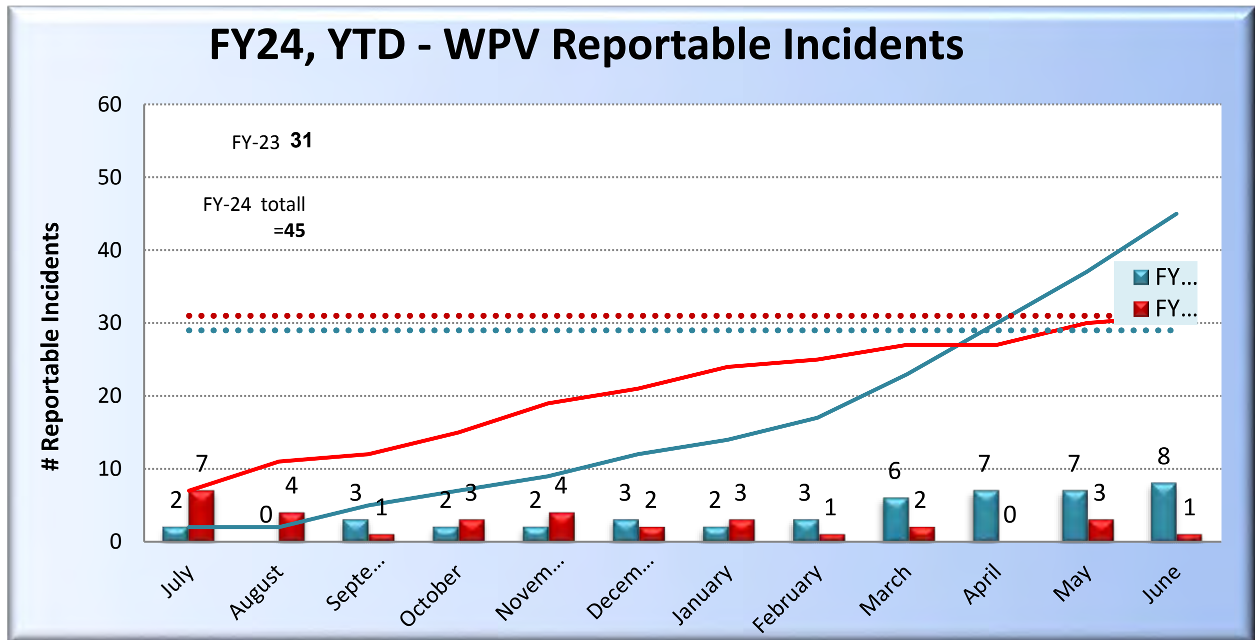
EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Decrease the rate of bloodborne pathogen exposures from 1.20 to 1.08	EWHS /EH&S	**Goal not met.** Rate increased to 2.7 in FY-24 compared to 1.2 in FY-23.

- **Measurement of success**: This goal was not met. Organization incidence of bloodborne pathogen exposures returned to increased levels observed prior to FY-20. In response, EWHS initiated:
    - Joining tier 1 huddles across the enterprise emphasizing the importance of BBPE prevention to meet employees where they are at the start of their shifts.
    - Established focus departments for further training or intervention when observed rates exceeded historical data norms.
    - Analyzed patterns of injuries to partner with Clinical Education in targeted prevention education efforts.
    - Examined ways to improve employee safety such as partnering with clinical leadership, Supply Chain Management, and Security to examine eyewash station placement for future enterprise-wide rollout for facial splash exposures to blood, bodily fluids, and other hazards.

Security Management

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY24. The data includes activity from both campuses.



Review of the FY24 WPV incidents showed:

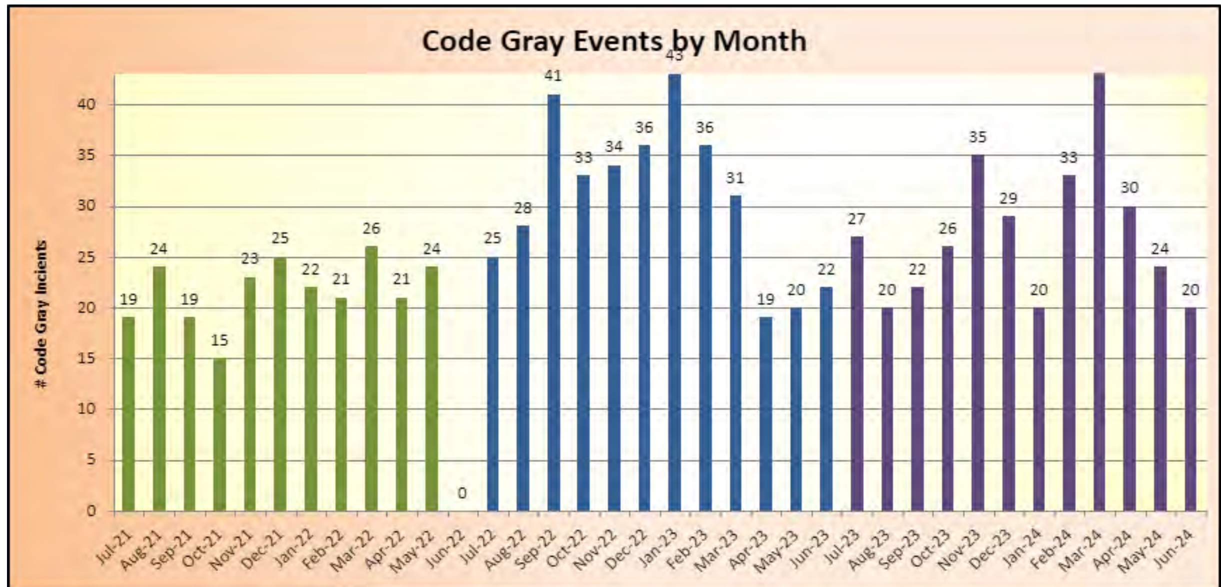
There were 45 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 24. This is a 45% increase from FY23.

- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

1. **A significant increase in the number of WPV events related to confused or dementia patients.**
2. **A moderate increase in the number of WPV events related to behavioral health patients.**

- **Code Gray Responses:**

  Code Gray responses decreased (11%) in both MV and LG. The total number of incidents in FY24 was 327 compared to 368 in FY23. The decrease in code greys is largely due to the implementation of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the activation of the portable panic button program in Los Gatos in March 2024.



Effectiveness

Key performance indicators were identified in FY24 to improve Security Management within the Environment of Care.

1) 5% reduction in number of reportable workplace violence incidents- In FY24 there was a 45% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

This goal was not met.

2. 10 % reduction in the number of Code Greys over FY 2023. In FY 24 there were a total of 327 code greys. This is a 11% reduction in the number of code greys.

This goal was met.

Hazardous Material Management

Effectiveness

- In FY 24 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation compliance:
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors

- Monthly Safety Rounds that include observation of waste segregation practices
- Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
- Working with Outside vendor on Code Orange Response process and procedures.
- Regular **Hazardous Materials Work Group** Meetings with the goal for discussion with high risk hazardous materials and waste departments.

FY-24 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
    - **Measurement of success** :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
    - **Measurement of Success**: >95%. **This goal was accomplished**.

Fire Safety Management

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY24.

A. Fire Incidents

There was no fire incident in Mountain View or Los Gatos in FY24.

B. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated for potential opportunities for improvement.

The total number of events in FY24 (47) was slightly higher than FY23 (45). There were 45 events in Mountain View and 2 in Los Gatos. This increase was mostly related to significant construction activities at both hospitals during FY24.

D. Effectiveness

Based on opportunities for improvement identified in the FY23 annual EOC evaluation the FY24 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY25 due to staff performance in FY24.

Medical Equipment

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-24.

A. Reports to the FDA –

There were 6? reports through the Medwatch[1] system in FY-24. There were no patient deaths associated with any of the reports.

B. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-24. A 6% improvement from FY-23. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought up the completion rate to 96%.
- All high risk, life safety equipment was maintained at 98.99% completion rate. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.42%. Only two devices(external pacemakers) could not be located for 100% completed maintenance.

C. Product Recalls Percentage Closed / Received

For FY-24, there were 465 recorded equipment recalls: 44 still open.

Effectiveness

[1] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

FY24 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

Raise the percentage of the total database completed that is currently at 96.77% to 98%. This will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.

Goal was met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 98.82%.

Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.

Goal was not met. Reduced all ECRI alert/recalls by 75% or 88 open ECRI alerts.

Utility Systems

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-24.

A. Utility Reportable Incidents

There were four incidents in FY-24. All were electrical outages or voltage fluctuations.

- Los Gatos had a temporary loss of electrical utility to the campus on February 4th, 2024, at 05:00. Los Gatos experienced a power fluctuation that tripped the breaker to the MRI trailer. There was no impact to patient safety related to this event. On April 15th, 2024, the Los Gatos Rehabilitation building loss PG&E supplied power at 18:15 due to an offsite power disruption. This outage lasted until 19:10. The emergency generator number 3 which supplies the Rehabilitation building supplied emergency power for 55 minutes. There was no impact to patient safety related to this event.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates,2/4/24, 2/9/24. These events were weather related disruptions, and the emergency generators ran and functioned as designed:

Effectiveness

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

Emergency Management

Performance

- Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant, events are presented to the Central Safety Committee for their review. The following Emergency Management indicators were reported in FY24.

A. Activation of Hospital Incident Command System (HICS)

- There were no recorded events and/or emergencies during FY24 requiring activation of HICS and opening of the Hospital Command Center (HCC).
- **FY24 Goals**
  1. Expand the use of the El Camino Health mass notification system (Everbridge) to all employees (continued from FY23)
     - **Measurement of Success**
       - Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
       - Evaluate and set up logical groups and rules for notifications. **In progress**
       - Train key staff to be able to use/send alerts.
     - **This *goal was accomplished.***
       - All employees with Workday accounts are now included in a nightly update of the Everbridge database.
       - Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
       - Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.
  2. Implement additional layers of communication redundancy to include:
     - **Measurement of Success**

- Transition cellular service from AT&T to FirstNet which allows for the use of deployable satellite assets during a communication failure.
- Train and provide resources to an internal amateur radio team.
    - **This *goal was accomplished.***
- Partnered with Supply Chain to create a contract with FirstNet and ensure a smooth transition of services.
- Hosted several internal and community wide amateur radio certification and licensure courses in M.V. and L.G.

EC 1.0 - Safety Management

Work Group Chair: ***Michael Rea***

Scope

Safety Management is the responsibility of health system leaders and every employee is responsible for the safe environment of care. Departments that have a specific role in the promotion and management of a safe environment may include, but are not limited to the following functional areas:

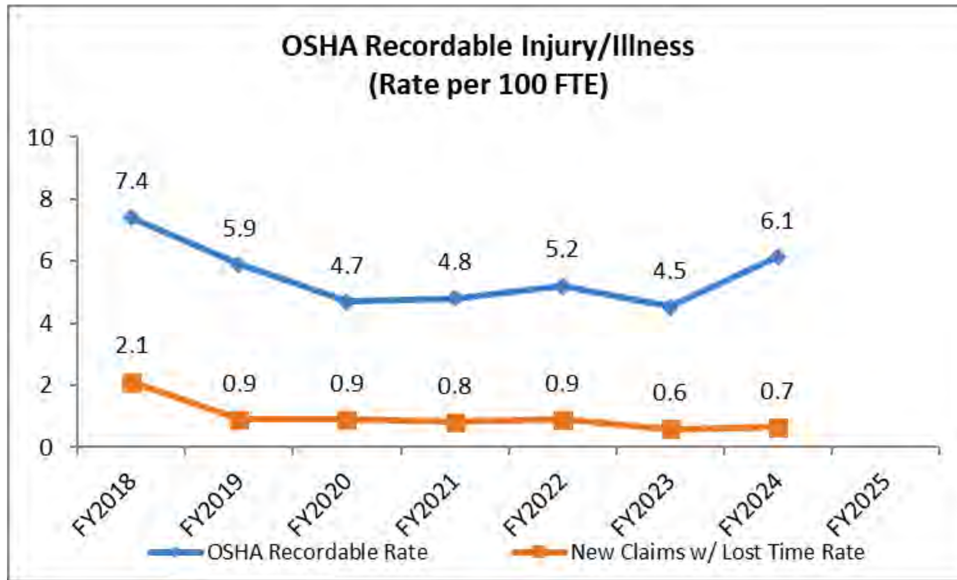
- Employee Wellness & Health Services
  - Education Services
  - Quality and Patient Safety
  - Infection Prevention
  - Security Management
  - Environmental Services
  - Facilities Services
  - Patient Care Services
  - Human Resources
  - Radiation Safety

Performance

Performance indicators offer the opportunity to objectively assess areas of focus and identify potential risk. Indicators are reported on the Central Safety Committee Trend Report, and evaluated annually. The following performance criteria are the indicators used to monitor Safety Management in FY-24. This includes data from both the Mountain View and Los Gatos campuses.

B. OSHA Recordable Injury & Illness

The rate of OSHA recordable incidents per 100 Full Time Equivalent employees (FTE) increased in FY-24 to 6.1 as compared to 4.5 in FY-23. The change is directly attributed to increased reporting of injuries that do not involve lost time or job transfer. Contributing factors to this increase include increased departmental outreach and education at Tier 1 daily huddles, Management Team attention and sharing lessons learned at Enterprise Huddle, and a focus on prompt employee reporting of bloodborne pathogen exposures (needlesticks). The rate of claims with lost time per 100 FTE remained stable at 0.7 in FY-24 compared to 0.6 in FY-23. Thus, although overall injury reporting is increasing, injuries of consequence remain stable.



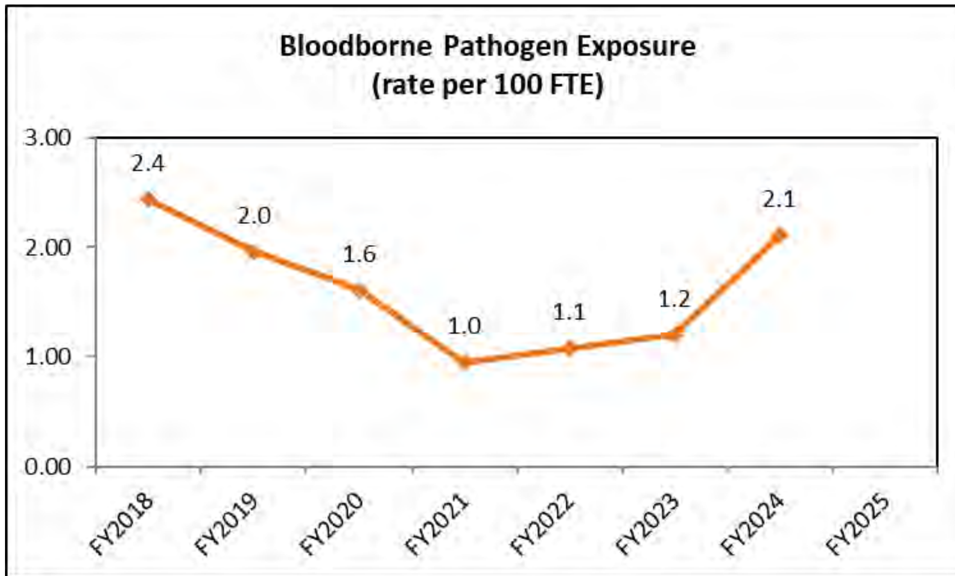
The lost workday rate for reported injuries (per 100 FTEs) increased to 0.7 in FY-24 compared to 0.6 in FY-23.

Analysis

- In FY-24, the rate of OSHA recordable injuries increased 35% compared to FY-23 and the loss time rate observed an absolute increase of 0.1 (17%) compared to FY-23.
- Injury Rates**:** The three largest injury types contributing to the Cal/OSHA recordable injury and illness rate were strains and sprains at 42%, blood and bodily fluid exposures (e.g. needlesticks and other exposures to blood) at 20%, and contusions at 16%. There were 12 (6%) Cal/OSHA recordable injuries due to patient agitation (e.g. workplace violence).
- In FY-24 bloodborne pathogen exposures due to needle sticks increased to 28 injuries compared to 22 injuries in FY-23. An overall increase in exposures such as splashes of bodily fluids to the eyes was noted. Improvement strategies will be explained in the bloodborne pathogen exposures section below.

Improvement Strategies:

The OSHA recordable rate of bloodborne pathogen exposures increased in FY 24 returning to before COVID-19 pandemic incidence levels. That is, the improvement observed in FY 21, FY 22, and FY 23 was not sustained. More information is contained in the bloodborne pathogen exposure section below.



Slips, trips, and falls among employees continued the overall net decrease in FY 24 compared to the baseline period in FY 17. More information is contained in the slips, trips, and falls section below.

C. OSHA Recordable Injury/Illness Rates as Compared to US & CA Hospitals

The Department of Labor, Bureau of Labor Statistics (BLS) calculates the recordable injury and illness rates for all hospitals in the USA and California[2].

The ECH injury/illness rate in ***calendar year 2023*** was 5.3, which is comparable to the California state and national averages in 2022 (6.1 and 5.7, respectively where 2022 is the most recent year available from the BLS). The ECH lost work cases rate was 0.7,

[2]The BLS data is calculated by calendar year. 2022 is the most recent calendar year of injury and illness data available as of August 20, 2024.

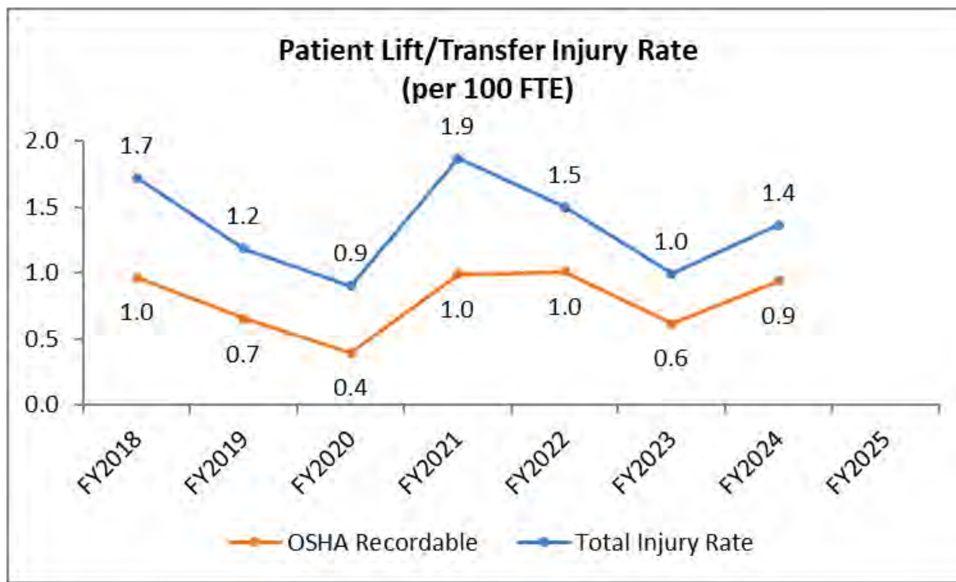
which is below both the state and national average. The lower rate in lost time incidents is due to overall prevention efforts departmental outreach.

El Camino Health's robust Transitional Work Assignment Program shows a commitment to keeping employees safely working and engaged through an injury or illness. This innovative program accounts for the nearly three-fold increase in transitional work cases (3.5) relative to the state and national rates of Cases with job transfer or restriction (0.8 and 0.8, respectively).

D. Safe Patient Handling and Mobility (SPHM) Injuries

Analysis

- **Injury Rates**: **Injury Rates**: The rate of OSHA recordable SPHM injuries per 100 FTEs **increased in FY-24, from 0.6 in FY-23 to 0.9 in FY-24.**
- **Total Injuries**: The overall number of SPHM injuries (42) and those that are OSHA recordable (29) represent an increase compared to FY 23 but still within program performance norms observed since FY 18.



SPHM Injuries: Total Reported vs OSHA-Recordable (Fiscal Years 18-21)

SPHM Injuries	2017	2018	2019	2020	2021	2022	2023	2024
Total Reported	44	41	29	23	50	37	29	42
OSHA-recordable	29	23	16	10	26	28	18	29
% OSHA	66%	56%	55%	43%	52%	76%	62%	69%

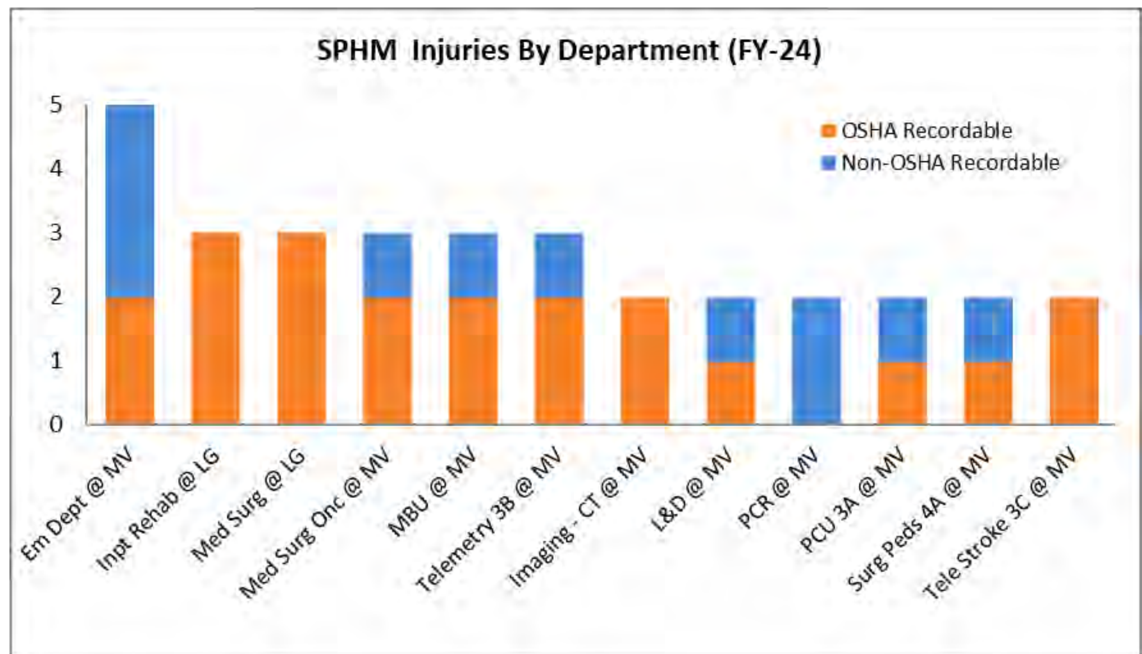
- **Lost/Restricted Days due to SPHM Injuries:** Of the 29 OSHA-recordable injuries, 8 resulted in lost days.

SPHM Injuries by Type, Fiscal Years 17 – 23

Activity	2017	2018	2019	2020	2021	2022	2023	2024
Combined Transfer	6	5	5	2	3	1	4	1
Cumulative Pt Handling	5	4	0	1	2	5	1	2
Lateral Transfer	8	1	5	3	9	4	3	4
Patient fall/prevention	5	9	8	8	10	3	9	4
Car extraction	0	0	0	1	2	1	0	0
Pt Holding	2	3	2	1	5	0	1	4
Turning/Pulling	12	16	5	6	17	11	9	18
Vertical Transfer	5	3	4	1	2	3	1	4

- Turning/pulling persists as the top category of SPHM injuries.

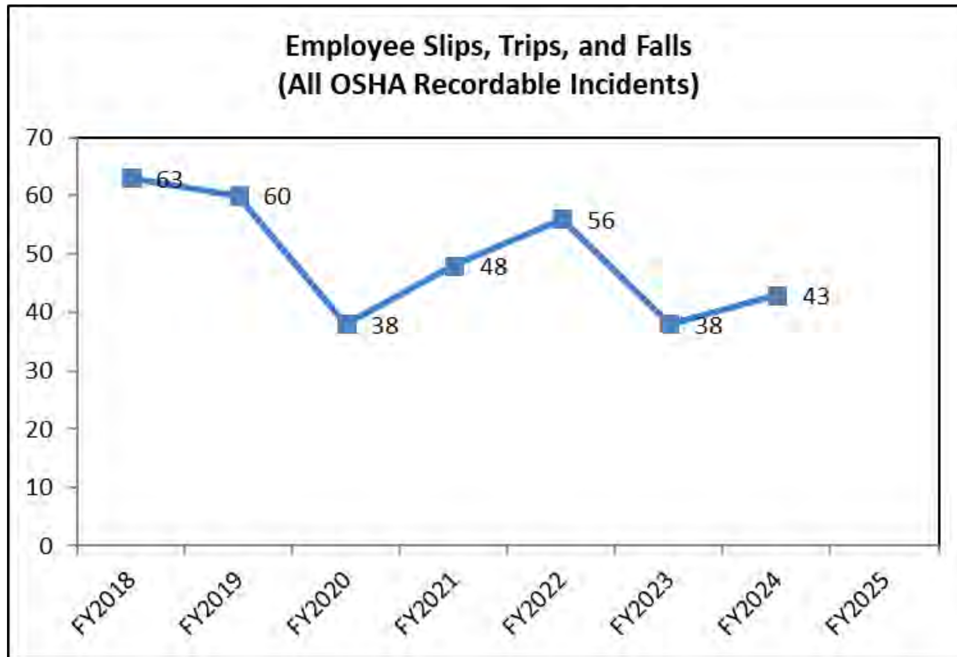
- **Injuries by Department**



- Inpatient Rehabilitation @ LG observed 3 OSHA Recordable SPHM injuries in FY 24 compared to 3 OSHA Recordable and 1 non-OSHA Recordable injuries in FY 23.
- Medical Surgical @ LG observed 3 OSHA Recordable SPHM injuries in FY 24 compared to 2 OSHA Recordable and 2 Non-OSHA Recordable SPHM injuries in FY 23.
- Patient Care Resources @ MV observed a decline in SPHM injuries noting 2 Non-OSHA Recordable SPHM injuries in FY 24 versus 2 OSHA Recordable and 2 Non-OSHA Recordable SPHM injuries in FY 23.
- Mother Baby Unit @ MV and Medical 2C @ MV represent two departments with consistent OSHA Recordable SPHM injuries.

- EWHS partnered with the Mother Baby Unit @ MV to conduct a worksite evaluation of the newly renovated patient rooms and propose strategies to mitigate the risk of SPHM injury.

E. Slips, Trips, Falls Injuries



Analysis:

- **Injury Incidence**: Targeted interventions to reduce Slip, Trip, and Fall (STF) injuries were initiated in FY-17 due to the consistently rising incidence. The decrease in STF injuries was sustained in FY 24 with 43 STFs.
- The number of OSHA-recordable STFs was 8.
- **Injury Types:**

  - Employees who reported distraction as the root cause of the slip, trip, and fall were the leading category (n=7). Of note, contaminants/slippery floor is no longer a leading cause of slips, trips, and falls (n=3); a substantial reduction from a high of 20 in FY-22.
  - Bodily reaction, or “I just fell” (n=4) was the second most common cause.

An employee sustained a serious injury requiring hospitalization from a STF in April 2024. The employee sustained a slip, trip, and fall over parked equipment in a Main

Operating Room passageway. The injury was reported to CAL/OSHA who conducted a site visit on 04/18/2024.

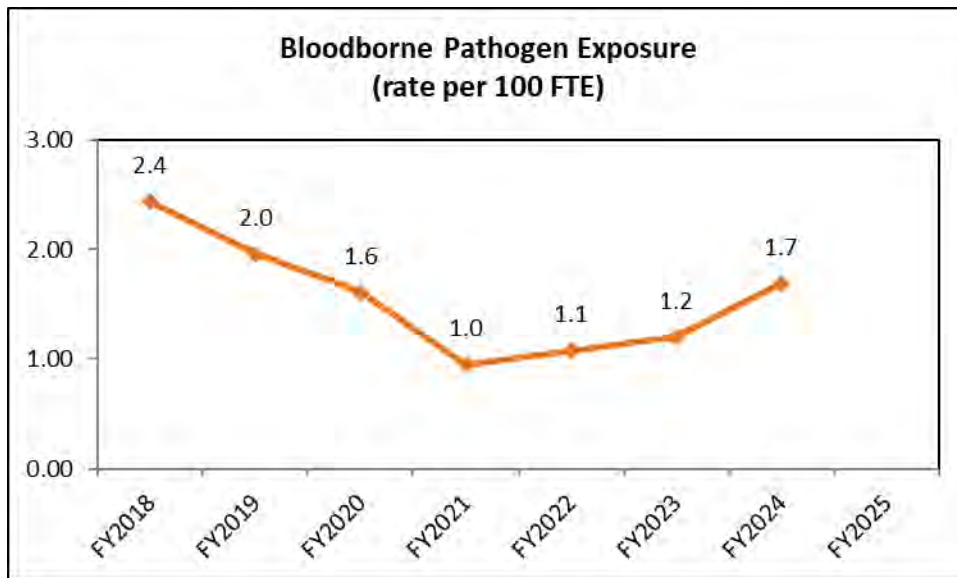
Improvement Strategies:

- EWHS and Management continue to partner with Facilities to identify and mitigate hazards to ensure the same injury does not occur twice.
- Increased focus on floor contaminants (e.g. wet surfaces) and a major decline from n=9 slips, trips, and falls in FY-23 to n=3 in FY-24.

  Adding report-outs to OSHA Recordable incidents at Enterprise Huddle to share lessons learned related to universal skills.

F. Bloodborne Pathogen (BBP) Exposures

The rate of bloodborne pathogen exposures per 100 FTE **increased to 1.7 in FY-24 compared to 1.2 in FY-23.** The total number of exposures for both campuses increased to 52 exposures in FY-24 compared to 35 in FY-23. Of the 52 exposures in FY 24, 35 were percutaneous exposures and 17 were bodily fluid exposures due to splashes.



Analysis:

- The number of sharp injuries decreased in FY-24 to 6 compared to 7 in FY23:
- The number of needlesticks increased to 28 in FY 24 compared to 22 in FY 23.

G. TB Conversions

There were no known occupational exposure conversions during FY-23.

H. Safety Training Indicators

Ensuring staff receive the necessary and required training to safely perform their duties is a critical element of the safety program. A combination of classroom and computer-

based training is required for all employees. All employees complete new employee orientation upon hire. Annual regulatory review courses are required for all employees and are provided as online modules. The topics include fire, evacuation, hazardous materials, and other safety topics. The compliance rates for FY--24 are:

- New employee orientation: 100% (Target: 100%)
- Annual Regulatory Clinical Review: 93% (Target: 95%)
- Annual Regulatory Non-Clinical Review: 96% (Target: 95%)

Effectiveness

Key indicators were identified to establish goals for FY-24 with opportunities to improve Safety Management within the Environment of Care.

FY 24 Goals

2) Reduce employee bloodborne pathogen exposures.

EOC Area	Indicator	Responsible Dept./Function	Target
Safety	Decrease the rate of bloodborne pathogen exposures from 1.20 to 1.08	EWHS /EH&S	**Goal not met.** Rate increased to 2.7 in FY-24 compared to 1.2 in FY-23.

- **Measurement of success**: This goal was not met. Organization incidence of bloodborne pathogen exposures returned to increased levels observed prior to FY-20. In response, EWHS initiated:
    - Joining tier 1 huddles across the enterprise emphasizing the importance of BBPE prevention to meet employees where they are at the start of their shifts.
    - Established focus departments for further training or intervention when observed rates exceeded historical data norms.
    - Analyzed patterns of injuries to partner with Clinical Education in targeted prevention education efforts.
    - Examined ways to improve employee safety such as partnering with clinical leadership, Supply Chain Management, and Security to examine eyewash station placement for future enterprise-wide rollout for facial splash exposures to blood, bodily fluids, and other hazards.

EC 2.0 - Security Management

*Work Group Chair: **Matt Scannell***

Scope

The Security Management Plan is designed to promote a safe and secure environment and to protect patients, visitors, physicians, volunteers, and staff from harm. Hospital security activities and incidents are managed by the Workplace Violence Committee and are reported to the Central Safety Committee. This data includes, but is not limited to, the following:

- Accidents
- Audits/Inspections
- Assaults
- Burglary
- Code Gray
- Code Green
- Code Pink/Purple
- Disturbance
- Fire Drills
- Missing Property
- MV/LG Community Crime Data Analysis
- Parking Management
- Robbery
- Suspicious Activity
- Thefts
- Trespassing/Loitering
- Vandalism
- Workplace Violence Events Review

Workplace Violence Prevention Plan

The Workplace Violence Prevention Plan is required by Cal-OSHA (Section 3342 of Title 8 of the California Code of Regulations). This plan is specifically for healthcare workers. The WPVP program at El Camino Health is overseen by the Workplace Violence Prevention Committee. There are four required elements to the plan:

1. Written Plan: The plan is reviewed and updated annually.
2. Response: The plan includes a comprehensive violent incident investigation process.
3. Training: The hospital has developed two levels of training.
   - **AVADE** – Computer based training module assigned annually to most staff.
   - **Nonviolent Crisis Intervention (NCI) training** – module and classroom assigned to employees working in departments considered "High Risk" whose assignments may involve confronting or controlling persons exhibiting aggressive or violent behavior. This class is assigned to:
     - Behavioral Health
     - Emergency Department
     - Security
     - Assistant Hospital Managers (Hospital Supervisors)

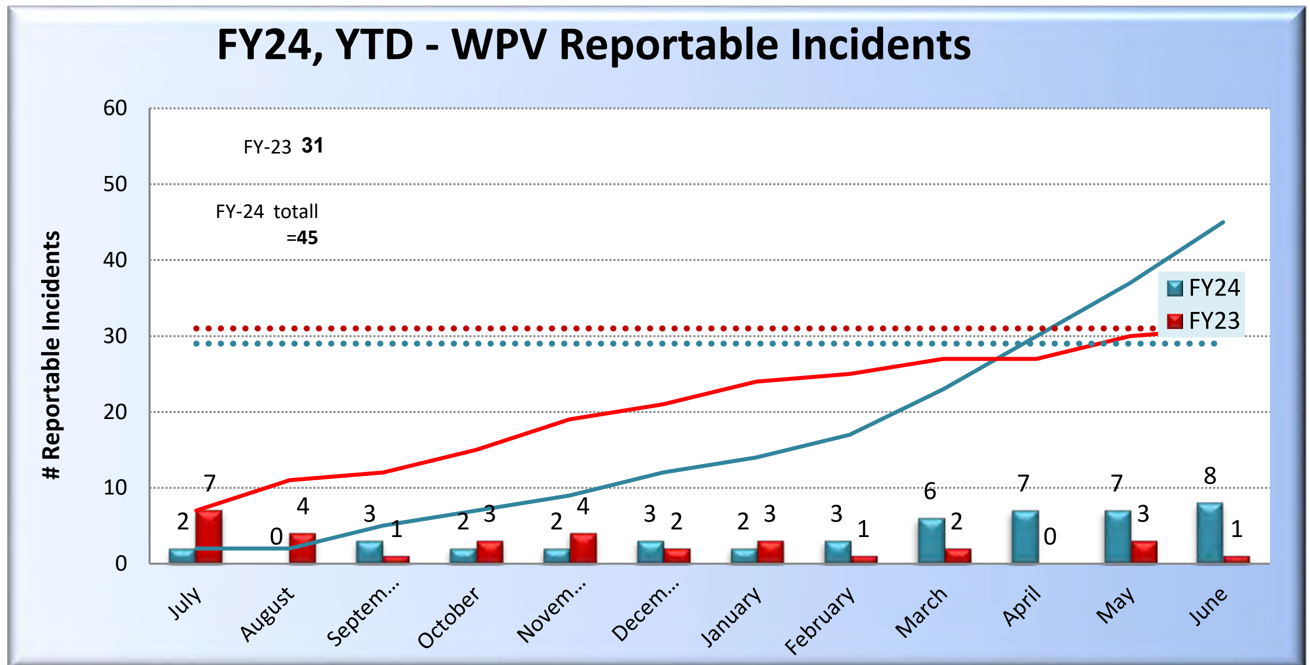
   Note- The hands-on portion of the class was restarted in February of 2023. This training was revised to include a three-hour mental health component.
4. Reporting: An ongoing WPV reporting team ensures reporting is completed as required.
   - OSHA requires reporting of ALL physical assaults of employees regardless of whether the incident resulted in an injury or not.
   - In FY24, 45 incidents reported to the CAL-OSHA WPV website. There were no major WPV related injuries reported to the CAL-OSHA district office.

Performance

Performance indicators for the Security Management program are reported and trended monthly and/or quarterly to the Central Safety Committee and are reflected in the "Trends Report". The following performance criteria monitor Security Management for FY24. The data includes activity from both campuses.

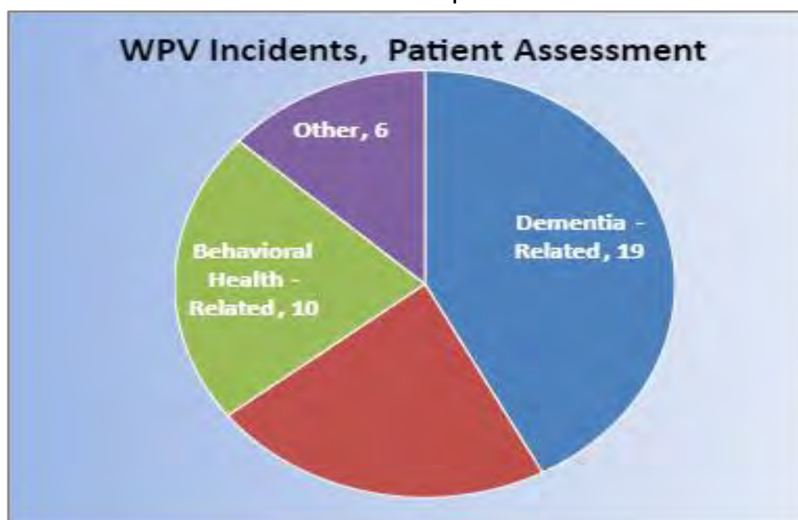
Review of the FY24 WPV incidents showed:

- There were 45 Workplace Violence (WPV) incidents reported to CAL-OSHA in FY 24. This is a 45% increase from FY23.



- Contributing factors to this increase in reportable CAL-OSHA workplace violence incidents can be attributed to the following:

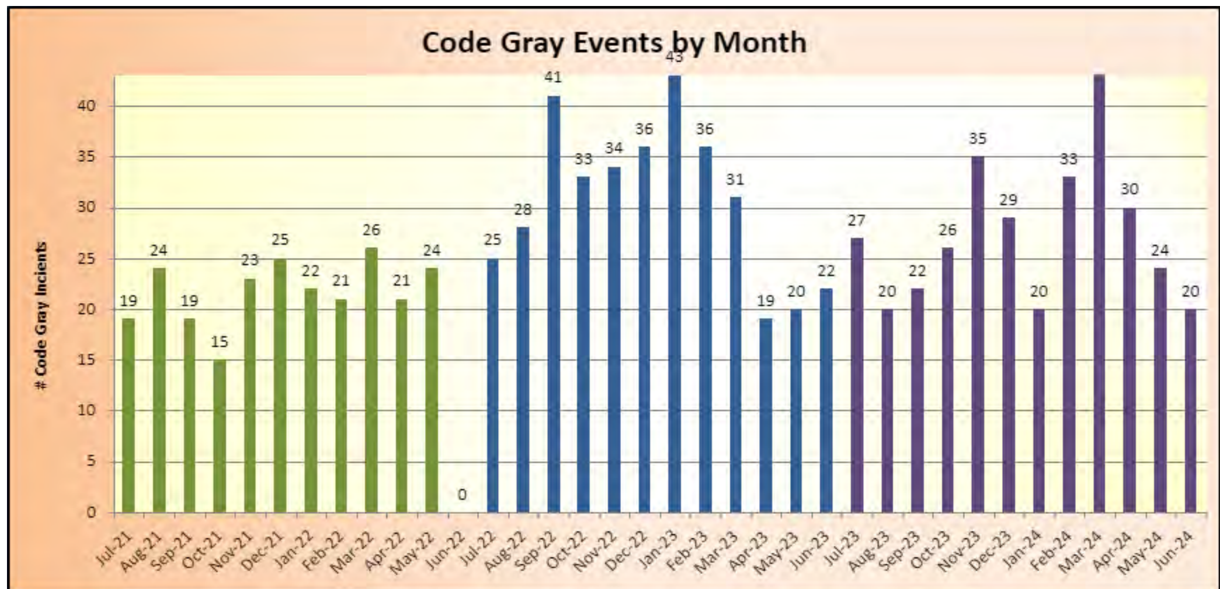
  1. A significant increase in the number of WPV events related to confused or dementia patients.
  2. A moderate increase in the number of WPV events related to behavioral health patients.



Note – A focus on managing our dementia related patient population will occur in FY 25.

A. Code Gray Responses

Code Gray responses decreased (11%) in both MV and LG. The total number of incidents in FY24 was 327 compared to 368 in FY23. The decrease in code greys is largely due to the implementation of the CALM (Collaborative Aid through Listening and Motivation) team in M.V. and the activation of the portable panic button program in Los Gatos in March 2024.



Data shows Code Gray incidents and other urgent requests for Security assistance appear to occur with greater frequency in the ED and Medical Units:

- **MV Emergency Dept. (ED) – 36%**
- **Medical Unit (4A)- 13%**
- **MV Medical Unit (3C) – 11%**
- **Medical Unit (3B)- 8%**

Responses are tracked through the Code Gray security shift report form and monitored to help identify possible improvements to the process.

B. Security Incidents

There was a total of 567 reported security incidents for FY24 requiring a security response. This is a slight increase from FY23 of 547.

C. Bulletins, Alerts & Presentations

Security Services issued six personal safety alerts, security prevention announcements, law enforcement advisories and awareness presentations and other hosted discussions.

D. Patient Belongings

Security Officers performed 6,365 chain-of-custody transactions involving patient's belongings in FY 24. This was slight increase over FY 23.

E. Fire Drills / Fire Watches

Security Officers conducted 96 fire drills and 6 fire watches were performed in FY24.

F. ID Badges

Security Badging Services issued approximately 3,500 El Camino Health badges in FY 24, which was an increase of approximately 1,000 Photo ID Badges (mostly related to removing RN's last name as part of the nursing contract). This provides access and barcoding technology to staff, physicians, auxiliary, contractors, and students. Additionally, in FY 24 approximately 350 temporary badges were issued to staff who forgot, or temporality lost their badges.

G. Investigations & Audits

Security Services performed 129 investigations and audits including, but not limited to fact-finding, interviews, case follow-up documentation, intelligence gathering, and physical security assessments or systems review.

H. Lost and Found

Security Officers performed 496 chain-of-custody transactions involving Lost and Found items for patients, visitors and staff.

I. Inspections

Security Services performed a total of 84,423 inspections (weekly and monthly items) including but not limited to fire extinguishers, eyewash stations, panic buttons, exterior campus lighting, emergency phones and delayed egress door checks.

J. Loitering

Security Officers responded to 327 incidents involving problematic individuals who required extra time and assistance leaving hospital property. Note: These incidents may be a subset of data from other sections in this report.

K. Parking Compliance & Services

In addition to daily parking control and 'space availability' counts, Security Officers performed 93 vehicle-related services including jump-starts, door unlocks and tows. 865 citations and warnings were issued to vehicles on Mountain View and Los Gatos campus.

L. Police Activity

Law enforcement agencies were on-site 141 times in response to requests for assistance, urgent calls and for investigative activities. Note: actual number maybe higher, as Security Services may not be aware of all police activity on-campus.

M. Effectiveness

Key performance indicators were identified in FY24 to improve Security Management within the Environment of Care.

FY24 Goals

2) 5% reduction in number of reportable workplace violence incidents- In FY24 there was a 45% increase in the number of Workplace Violence reports submitted to CAL-OSHA.

This goal was not met.

2. 10 % reduction in the number of Code Greys over FY 2023. In FY 24 there were a total of 327 code greys. This is a 11% reduction in the number of code greys.

This goal was met.

EC 3.0 - Hazardous Materials & Waste Management

*Work Group Chair: **Lorna Koep***

Scope

The Hazardous Materials & Waste Management work group is comprised of a multi-disciplinary group from within El Camino Health. The work group chair serves as the central contact point for the reporting and documentation for the work group and provides regularly scheduled reports to the Central Safety Committee.

Performance

A. Hazardous Material Incidents

The Hazardous Materials and Waste Management Work Group maintains an electronic Hazardous Materials Spill Log, which documents reporting and clean up procedures used.

Recordable Hazardous Material Incidents:

1) 9-18-23 Nitroglycerin/Dextrose Pharmacy Mix leaking through 1 box – Loading Dock – Fedex offloaded box that was leaking. Container was shipped in a failed container and was not noticed immediately due to volume of shipments being received at the same time. Gap identified with incomplete Code Orange Response Team presence. Education to staff to not to accept leaking boxes, place immediately in secondary containment immediately, and safety. Cleanup was handled safely.
2) 1-8-24 Perjeta 250ml spill – Cancer Center, Oak Pavilion – RN did not re-attach the Primary IV line to the patient. Reviewed/educated RN staff to double check all connections prior to administration. Cleanup was handled safely.
3) 2-9-24 Oxytocin 50-100 ml spill - MV Mother Baby Unit – IV bag leaking from the hose connection. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
4) 4-3-24 /Chemo Drug 30-50 ml spill – Cancer Center, Oak Pavilion – IV bag leaking from the hose connection. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
5) 4-12-24 Taxol/Chemo Drug 234 ml spill – Cancer Center, Los Gatos – IV bag leaking from white port hose connection. Full Code Orange Response Team present. White port accessed and no malfunction identified. Education to staff to double check all connections prior to administration. Cleanup was handled safely.
6) 6-8-24 Doxorubicin, Etoposide, Vincristine/Chemo 1000 ml Spill - 3C 3323 Nurse was planning to start infusion of a new bag of chemotherapy when the patient needed to use the bathroom. Patient used IV pole for support when walking, but the IV pole fell over and the IV bag of chemotherapy hit the floor and ruptured.. 4B chemo nurses took initiative to clean spill on their own. Reinforced Safety, Isolate, Notify (SIN). Education on code orange process moving forward. Hot wash Conducted 6-20-24. Gaps and Opportunities identified. Working with consultant on Code orange revision, spill response

training/drills. During the interim, call vendor for all spills until code orange response is where it needs to be

- **Reportable Hazardous Material Incidents** – There were no reportable spills in FY 24.

B. Waste Water Discharge Violations:

- **There were no wastewater discharge violations in FY 24.**

C. Monitoring and Inspections

- **Hazardous Waste Inspections** – There were no hazardous materials and or waste inspections in FY 24.

- **Santa Clara County Annual Medical Waste Inspections** – There were no medical waste inspections in FY 24.

  - **In FY 24 the organization focused on the following monitoring and education of staff to ensure medical and hazardous waste segregation compliance:**
  - Annual Waste Management education for staff
  - Daily rounds by EVS supervisors
  - Monthly Safety Rounds that include observation of waste segregation practices
  - Quarterly Surveys of medical waste/sharps by Stericycle Compliance Coordinator with targeted education on nursing units addressed toward survey findings.
  - Working with Outside vendor on Code Orange Response process and procedures.
  - Regular **Hazardous Materials Work Group** Meetings with the goal for discussion with high-risk hazardous materials and waste departments.

D. Radiation Safety Committee

The Radiation Safety Committee reports to Central Safety as part of the Hazardous Materials Management work group. Minutes of the Committee meetings are reviewed quarterly at the Central Safety Committee.

Effectiveness

Staff training on hazardous materials is completed through computer-based training modules and is reported by the Safety Management Work Group. In addition, representatives from all areas represented in the Hazardous Materials Work Group completed a 40-hour HAZWOPER[3] training course.

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve hazardous materials & waste management.

[3] HAZWOPER: Hazardous Waste Operations and Emergency Response

FY-24 Goals:

1. Staff knowledge on the length of time you should wash your eyes at an eye wash station after an exposure (15 minutes)
    - Measurement of success :> 95%. **This goal was accomplished.**
2. Staff can describe the process for accessing a safety data sheet.
    - Measurement of Success: >95%. This goal was accomplished.

EC 4.0 – Fire Life Safety Management

Work Group Chair: John Folk

Scope

The Fire Life Safety Management Plan is designed to assure appropriate, effective response to a fire emergency that could affect the safety of patients, staff, and visitors, or the environment of El Camino Hospital. The program is also designed to assure compliance with applicable codes, standards and regulations.

Performance

Performance indicators for the Fire Safety Management program are reported monthly and/or quarterly to the Central Safety Committee and are reflected in the Trends Report. The following performance criteria are reflective of the indicators established in monitoring Fire Safety Management for FY24.

C. Fire Incidents

There was no fire incident in Mountain View or Los Gatos in FY24.

D. Fire Alarm Events

A fire alarm event is the activation of the fire alarm system determined not to be due to an actual fire incident. All incidents are evaluated for potential opportunities for improvement.

The total number of events in FY24 (47) was slightly higher than FY23 (45). There were 45 events in Mountain View and 2 in Los Gatos. This increase was mostly related to significant construction activities at both hospitals during FY24.

C. Fire Drills Completed / Scheduled

All required fire drills were completed in FY24. All opportunities for improvement are corrected on the spot, through facility work orders or with further education by the dept. Manager.

E. Effectiveness

Based on opportunities for improvement identified in the FY23 annual EOC evaluation the FY24 performance improvement Indicators were as follows:

EOC Area	Indicator	Responsible Dept./Function	Target
Fire Prevention	Staff knowledge on PASS- Pull, Aim, Squeeze, Sweep	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of horizontal and vertical evacuation (defend in place strategy move to next smoke compartment).	Engineering, Security and Department Managers	> 90%- Goal was met
Fire Prevention	Staff knowledge of the facility emergency phone number (55)	Security and Department Managers	> 90%- Goal was met

Note: We will choose all new indicators for FY25 due to staff performance in FY24.

EC 5.0 - Medical Equipment Management

Work Group Chair: ***Jeff Hayes***

Scope

The scope of the Medical Equipment Management Plan encompasses all medical equipment used in the diagnoses, monitoring and treatment of patients. The Medical Equipment

Management Work Group supports the delivery of quality patient care in the safest possible manner through active management of medical equipment.

Clinical Engineering supports all medical equipment. This process is reported to, and overseen by, the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually. Performance indicators are monitored monthly or quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Medical Equipment Management for the FY-24.

D. Reports to the FDA –

There were **X** reports through the Medwatch[4] system in FY-24. There were no patient deaths associated with any of the reports.

E. Preventative Maintenance (PM) Completion Rate Percentage

The PM completion rate did not meet compliance for the target of 95% completion in all areas.

- The completion rate for Clinical Engineering achieved 93% for FY-24. A 6% improvement from FY-23. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought up the completion rate to 96%.
- All high risk, life safety equipment was maintained at 98.99% completion rate. Maintenance on all devices are 100% managed through a communication process to locate all devices and when located completed. That managed process brought the completion rate to 99.42%. Only two devices(external pacemakers) could not be located for 100% completed maintenance.

F. Product Recalls Percentage Closed / Received

For FY-24, there were 465 recorded equipment recalls: 44 still open.

Effectiveness

[4] The FDA Medwatch System is used to report all incidents impacting patients and not only serious events resulting in patient deaths.

FY24 Performance Indicators

This year the performance improvement was focused on asset management and Cybersecurity.

Raise the percentage of the total database completed that is currently at 96.77% to 98%. This will confirm that 98% of all inventoried medical devices received a completed maintenance within the last 12 months.

Goal was met. We have raised the asset confidence level (maintenance completed on any device within the last year) to 98.82%.

Reduce open ECRI recall/alerts by 80%. Currently at 331 open ECRI alerts.

Goal was not met. Reduced all ECRI alert/recalls by 75% or 88 open ECRI alerts.

EC 6.0 - Utilities Management

*Work Group Chair: **John Thompson***

Scope

The scope of the Utilities Management Plan encompasses all utilities used to support the mission and objectives of El Camino Hospital. The Utilities Management Work Group is designed to support the delivery of quality patient care in the safest possible manner through active management of all utilities systems. This process is reported to and overseen by the Central Safety Committee.

Performance

Performance indicators offer the opportunity to objectively assess areas of focus identifying potential risk. Indicators are reassessed annually as a function of the Central Safety Committee. Performance indicators are monitored quarterly and reflected in the Safety Trends Report. The following performance criteria are reflective of the indicators established in monitoring Utility Management for FY-24.

B. Utility Reportable Incidents

There were four incidents in FY-24. All were electrical outages or voltage fluctuations.

- Los Gatos had a temporary loss of electrical utility to the campus on February 4th, 2024, at 05:00. Los Gatos experienced a power fluctuation that tripped the breaker to the MRI trailer. There was no impact to patient safety related to this event. On April 15th, 2024, the Los Gatos Rehabilitation building loss PG&E supplied power at 18:15 due to an offsite power disruption. This outage lasted until 19:10. The emergency generator number 3 which supplies the Rehabilitation building supplied emergency power for 55 minutes. There was no impact to patient safety related to this event.
- Mountain View had a loss of electrical utility to the campus due to PG&E outages on the following dates,2/4/24, 2/9/24. These events were weather related disruptions, and the emergency generators ran and functioned as designed:

C. PM Completion Rate % completed/ scheduled

The Utility Systems PM completion rate was **95%,** meeting the goal of 95%. Critical systems were maintained as required for the facility operations.

D. Generator Test % completed/scheduled

The percentage of the generator tests completed was 100% with compliance in loads, times, and transfer switch testing frequencies.

Effectiveness

Key indicators were targeted to establish goals for FY-24. The following goals presented opportunities to improve Utility Management within the Environment of Care:

EOC Area	Indicator	Responsible Dept./Function	Target	Actual
Utility Systems	Staff can describe why it is important to not block oxygen shut off valves.	Engineering & Department Managers	> 90%	**88% Goal was not met**
Utility Systems	Staff can describe who has the authorization to turn off medical gas controls.	Engineering EH&S & Department Managers	>90%	**93%- Goal was met**

Note: Data is collected through fire drills and environment of care rounds.

EM – Emergency Management

Committee Chair: Bryan Plett

Scope

El Camino Health's Emergency Operations Plan (EOP) addresses all non-fire-related internal and external emergencies impacting the El Camino Health environment of care. The Emergency Management Committee is responsible for ensuring a effective response to these emergencies. The hospital collaborates with state and local emergency management organizations to coordinate community planning and response efforts. Although Emergency Management is a distinct chapter under The Joint Commission, annual reporting is integrated with the Environment of Care report.

Performance

Performance indicators for the Emergency Management program are reported to the Emergency Management and Central Safety Committees. Significant events are presented to the Central Safety Committee for review. For FY24, the following Emergency Management indicators were noted:

B. Activation of Hospital Incident Command System (HICS)

There were no recorded events and/or emergencies during FY24 requiring the activation of HICS and opening of the Hospital Command Center (HCC).

C. Exercises / Drills

The Joint Commission requires each facility to activate HICS and open the HCC for a surge of simulated or actual patients at least twice per year. In FY24, this was met through separate planned exercises at both campuses (see below). The exercises are summarized below. After Action Reports were created for each exercise that included action items to be implemented to improve future responses.

- 10/19/2023 – El Camino Health / Great Shakeout Earthquake functional exercise. This exercise tested Situational Assessment, Operational Communications, Public Warning, and Public Health
- 3/28/2024 – Mass Casualty Incident functional exercise. This exercise tested El Camino Health's ability to respond to a Mass Casualty Incident. The exercise specifically tested Bi Lateral Communication, Triage, Treatment, and Transportation, Family Assistance, and Internal Communications.
- 6/19/2024 – Statewide Medical Response and Surge Tabletop Exercise. This exercise was conducted in partnership with Santa Clara Valley Emergency

Preparedness Health Care Coalition and other hospitals throughout the county. This exercise specifically looked at Intelligence and Information Sharing, Operational Communications, Operational Coordination, and Public Health and Medical Services.

D. Emergency Management Training

- New Hire and New Manager Orientation: Emergency management training was provided to all incoming new staff members.
- Safety Coordinator Meetings: Held both in-person and via Zoom, consisting of various aspects of emergency management related training.
- CHA Disaster Preparedness Conference: The annual conference, hosted by the California Hospital Association in September, was well-attended by El Camino Health representatives. This year's conference was held in September.

E. Community Involvement

El Camino Hospital remains actively involved in the Santa Clara County Hospital Emergency Preparedness Program (SCCHEPP) and the Santa Clara County Emergency Preparedness Healthcare Coalition (EPHC). The SCCHEPP group meets monthly with representatives from all county hospitals and EMS to develop a collaborative emergency response and disaster plan. Additionally, the group organizes county-wide disaster exercises in which the hospital actively participates.

The EPHC extends similar emergency preparedness initiatives to all healthcare facilities in the county, including clinics and skilled-nursing facilities. The group meets quarterly to share information and provide training.

The Hospital conducts an annual Hazard Vulnerability Assessment (HVA) to evaluate the risk of various emergency situations. Separate HVAs are performed for the Los Gatos and Mountain View campuses to account for site-specific differences. Efforts are then directed towards mitigating the highest risks identified for the fiscal year.

- There were minimal changes to the top five HVAs at both campuses in FY24 based upon local and real-world events. The top five hazards by campus are:

Mountain View	Los Gatos
(1) Earthquake	**(1) Earthquake**
(2) Patient Surge	**(2) Utility Failure**
(3) Utility Failure	**(3) Patient Surge**
(4) IT System Outage	**(4) IT System Outage**
(5) Fire - External	**(5) Fire - External**

F. Effectiveness

Key indicators were targeted to establish goals for FY24. The following goals presented opportunities to improve emergency management.

FY24 Goals

1. Expand the use of the El Camino Health mass notification system (Everbridge) to all employees (continued from FY23)

    - **Measurement of Success**
    - o Automate the process of adding/maintaining the database in Everbridge – this will require extensive IS support.
    - o Evaluate and set up logical groups and rules for notifications. **In progress**
    - o Train key staff to be able to use/send alerts.
    - **This *goal was accomplished.***
    - o All employees with Workday accounts are now included in a nightly update of the Everbridge database.
    - o Groups are set up to allow custom notifications by campus, department, job classification, and geographic location.
    - o Call Center staff are being trained on the use of Everbridge to allow for rapid notifications as needed.

2. Implement additional layers of communication redundancy to include:

    - **Measurement of Success**

- Transition cellular service from AT&T to FirstNet which allows for the use of deployable satellite assets during a communication failure.
- Train and provide resources to an internal amateur radio team.
    - **This *goal was accomplished.***
- Partnered with Supply Chain to create a contract with FristNet and ensure a smooth transition of services.
- Hosted several internal and community wide amateur radio certification and licensure courses in M.V. and L.G.

Status **Pending** PolicyStat ID **17161780**

Origination	05/1998
Last Approved	N/A
Effective	Upon Approval
Last Revised	12/2024
Next Review	3 years after approval

Owner	Diane Wigglesworth: VP, Compliance
Area	Corporate Compliance
Document Types	Procedure

Conflict of Interest

COPY

COVERAGE:

This policy applies to El Camino Hospital (ECH) employees, members of the Hospital Board of Directors (including Directors who are also Directors of the El Camino Healthcare District Board), Hospital Board Advisory Committee members, consultants, contractors ~~who operate outsourced departments~~, ECH volunteers, Medical Executive Committee members, physicians who are chairs of ECH ~~committees (but not~~departments or medical staff committee, and Medical ~~Staff committees), physicians who are Medical~~ Directors ~~of ECH, and physicians who receive payments from ECH~~. Members of ECH's Medical Staff are also subject to the conflict of interest provisions found in the El Camino Hospital Medical Staff Bylaws.

PURPOSE:

The purpose of this policy is to ~~encourage~~require disclosure of situations where a person subject to this policy may have ~~an~~a personal financial interest in a transaction or arrangement contemplate by ECH which is, or could be deemed to be, a conflict of interest so that the situation may be appropriately reviewed and resolved. This policy is intended to comply with the applicable laws of the State of California and federal tax regulations governing nonprofit organizations.

STATEMENT:

It is the policy of El Camino Hospital to comply with all mandatory reporting requirements regarding conflict of interest. This policy requires the disclosure of interests that may be or may lead to a conflict of interest. Such disclosure is not a conclusion that a conflict of interest exists or that the interest would prevent a person from participating in a decision or activity. This policy is intended to protect the interests of ECH by immediately identifying situations where an ECH decision-maker may have an

interest so that such an interest may be fully understood and addressed before ECH enters into a transaction or other arrangement. This policy also addresses the circumstances where an interest is not identified or addressed prior to completion of the transaction. This policy states and implements, but does not expand, the requirements of state or federal laws governing conflicts of interest applicable to ECH as a nonprofit, public benefit tax-exempt corporation. In addition to this policy, El Camino Healthcare District Board Members and designated officials are also subject to the Districts Conflict of Interest Code, the California Political Reform Act of 1974, California Government Code section 1090, and their implementing regulations.

PROCEDURE:

A. **Overview:**

This Policy and Procedure has ~~three~~four critical elements:

1. **Training** All individuals subject to this policy will receive training on this policy upon hire and annually if they are required to submit and Annual Disclosure Statement.

2. **Annual Disclosure Statement** ~~**(Section F)** Certain individuals~~Individuals holding specified positions who make or influence ECH decisions, as stated in Section C must file an annual disclosure statement, the purpose of which is to permit the identification of any interest so that a conflict of interest, should it arise, may be promptly and appropriately resolved. The annual disclosure statement can help avoid a situation where ~~an~~a personal financial interest becomes a conflict of interest by, for example, deciding not to invite a person with a ~~large~~material ownership interest ~~in~~with an equipment vendor to serve on a committee deciding which equipment to purchase.

3. ~~**Specific Disclosure (Section G)** The purpose of specific disclosure is to ensure that disclosures of interests are made in the context of particular transactions. Should a specific conflict develop, or if the issue relates to a person not covered by the annual disclosure statement filing requirement, then a disclosure must be made. Individuals must report the potentially conflicting interest regarding a particular transaction over which the individual has influence or decision-making authority.~~**Specific Disclosure** All individuals subject to this policy, regardless of whether or not they are required to file an annual disclosure statement, are expected to immediately disclose any self report a situation where they or a Family Member (as defined in Section B-1), has a direct or indirect financial interest as described in Section B in a particular transaction or arrangement that the individual is involved in for ECH, and the influence or decision-making authority that the individual has with respect to the transaction or arrangement. The purpose of specific disclosure is to ensure that disclosures of interests are made in the context of particular transactions or arrangement before ECH enters into such transactions or arrangement, so that the individual can be reused appropriately if necessary, or other mitigating actions may be taken. Specific disclosures must be made regardless of whether or not the individual has filed an annual disclosure statement, and regardless of prior disclosures either through an annual disclosure statement or otherwise.

4. **Resolution Process** ~~**(Section H).**~~ If an actual or a potential conflict of interest arises in the context of a particular transaction, this policy contains, in Section ~~H~~E,

COPY

provisions (which vary depending on the nature of the disclosing individual's role) to determine whether a situation involves a conflict of interest and describes methods to resolve that conflict of interest.

In general terms, all matters with respect to this policy shall be addressed by ECH forthrightly, but persons involved in reviewing and investigating such matters shall treat such matters in the same manner and with the same discretion as in handling other matters involving personnel information of employees or others. Such discretion, however, shall not limit the ability to obtain information or to raise and address issues. All information relating to such matters may be disclosed to members of management with an interest in the matter, and the Compliance and Audit Committee~~, members of the Board,~~ and the Board.

B. **Interests:**

1. An interest exists in any situation in which the actions of a person subject to this policy (or his/her immediate family), which per IRS regulations and policy includes the person's spouse or domestic partner, sibling and their spouses, parent, grandparent, and great-grandparent, children and their spouses, grandchildren and their spouses, great grandchildren and their spouses and any other person living in the same household as the person subject to policy undertaken on behalf of ECH may result in a personal financial gain or advantage to the member or any ~~concomitant~~related disadvantage to ECH. Although it is impossible to list every circumstance giving rise to an interest, the following are examples of the kinds of activities or interests that might give rise to such a conflict and that must be reported as outlined in this policy.

   a. Business/Financial Affiliations:
   To serve as a director, officer, partner, employee, consultant, agent or advisor of ~~anyperson~~any person, firm, or organization which is a supplier of goods or services to ECH, or conducts research at ECH.

   b. Governmental/Position of Influence Affiliations:
   To hold any elected or appointed office or position in any branch of government or in any regulatory agency having authority or jurisdiction over providers of health care, generally.

   c. Other Hospital Affiliations:
   To serve as a volunteer or paid director, officer, partner, employee, consultant, agent, or advisor of any hospital, or health care facility not affiliated with ECH, located in Santa Clara County.

   d. Outside Interests:

      i. To have, directly or indirectly, an ownership compensation, or equity interest, or other financial interest (including a service agreement) with ~~a value greater than $2,000 in any outside concern which the person knows, or has reason to believe,~~an individual or entity that makes payments to or receives payments from ECH (whether on account of services, goods, loans or other transactions), or which provides services in competition with ECH, or which is negotiating or contemplating

COPY

a transaction or arrangement with ECH.

ii. To compete, directly or indirectly, with ECH in the purchase or sale of property or any property right, interest or service.

iii. Ownership in securities such as mutual funds, exchange-traded funds or other similar diversified investments vehicles are not considered interests provided that the person does not have control or influence over the investments decisions made by these funds.

e. Outside Activities:

i. To render directorial, managerial or consultative services to, or to engage in any financial transaction with, any person or ~~concern~~organization which does business with or competes with ECH.

ii. To render other services in competition with ECH.

f. Gifts, Gratuities, and Entertainment:

i. To accept a gift, gratuity, travel, entertainment, or other material benefit as described in Gifts or Business Courtesies to Physicians or Other Potential Referral Sources Policy from any person or concern that does, or is seeking to do, business with, or is a competitor of, ECH under circumstances from which it might be inferred that such a gift, gratuity, entertainment or other material benefit was intended to influence or possibly would influence the recipient in the performance of his/her duties.

COPY

g. Use of Confidential Information for Personal Gain:
To disclose or use, for personal profit or advantage, information relating to ECH's business, including but not limited to methods of operation, and research and product development.

C. **Disclosure Requirements:**

1. **Annual Disclosure Statement**. The individuals holding the following positions will be requested to complete and file a conflict of interest annual disclosure statement with the Corporate Compliance Officer. The Corporate Compliance Officer shall be responsible for the process of distributing such statements on an annual basis (the Corporate Compliance Officer may ~~be requested to complete and file an annual disclosure statement with the Corporate Compliance Officer. The Corporate Compliance Officer shall be responsible for the process of distributing such forms on a regular basis (the Corporate Compliance Officer may~~ determine to stagger the distribution over a period of twelve consecutive months), and to ensure the return of completed ~~forms~~conflict of interest annual disclosure statement. The Corporate Compliance Officer will review each ~~form~~ and address any conflicts noted in the annual disclosure statement as described in Section ~~H~~E of this policy:

a. ~~Member of the Board of Directors of ECH.~~

b. Member of the Hospital Board of Directors of ECH, including members

who are also District Board members. (District Board members must also complete form 700 and disclosures required by the California Fair Political Practices Act).

c. Hospital Board Advisory Committee members.

d. Member of the Medical Executive Committee of ECH.

e. Physicians who are Chairs of Departments or Medical Staff committees.

f. A physician who is ~~paid compensation of any kind by ECH~~a Medical Director.

g. Member of the management of ECH which, for this purpose, shall include all Chiefs, Presidents, Division Executives, Directors and Managers~~: \~~.

h. ECH employees who are members of the purchasing staff, the finance division staff, the business development division staff~~,~~ or any ~~billing~~other employee who ~~is not part of the finance division staff, any registration staff who is not part of the finance division staff, each employee engaged in business planning and analysis and each marketing employee who is not part of the business development division~~make decisions in their capacity at ECH that could be influenced by their personal interests.

i. ~~Members of Board and management committees who are not members of the Board.~~

j. Any other individual subject to this policy selected by the Corporate Compliance Officer, in consultation with the Chief Executive Officer or Chief Legal Officer.

COPY

2. **Updating Annual Disclosure Statement**. A person required to file ~~an~~a conflict of interest annual disclosure statement shall file an updated ~~form~~disclosure statement if a material change occurs during the year that causes them to have a financial interest of the type identified in Section B that was not otherwise disclosed within the annual disclosure statement. ~~A material change would, for example, involve a change in the employer of a member of a committee concerned with the acquisition of medical devices from employment by a medical group to employment by a medical device manufacturer. Making the specific disclosure described in Section G rather than updating the annual disclosure statement is an acceptable alternative.~~

3. **Review**. The Corporate Compliance Officer shall review all Annual Disclosure Statements and shall ~~regularly~~ report the organization's overall compliance with the policy to the Compliance ~~Oversight~~and Audit Committee regarding such disclosures. The Corporate Compliance Officer may consult with other personnel of ECH with respect to such disclosures in order to propose changes needed to prevent conflicts and shall make all appropriate disclosures to inform persons to whom such individual reports or who need to know such information in order to properly manage any potential conflicts of interest. Moreover, information regarding physicians will be disclosed and discussed with the Medical Staff leadership or Chief Medical Officer as appropriate.

D. **Specific Disclosure:**

1. Any person who has ~~a~~decision-making or other material role with respect to ~~a~~ECH's decision ~~by~~to enter into or refuse to enter into a transaction or arrangement with a third party, and who also has a direct or indirect interest in the transaction or arrangement, shall disclose the facts and circumstances to the responsible ECH ~~to enter into or refuse to enter into a~~employee involved in the transaction ~~with a third party and who also has a direct or indirect interest in the transaction shall disclose the facts and circumstances to the responsible~~or arrangement, provided that the employee holds a management position or higher. If the person making the disclosure is a member of the District or Hospital Board of Directors of ECH ~~employee involved in the transaction holding the position of a manager or above.~~, such disclosure shall be made to the Chairperson of the Board. If the person making the disclosure is ~~a member of the Board of Directors of ECH,~~the Chairperson of the Board, such disclosure shall be made to the Vice Chairperson of the Board. ~~If the person making the disclosure is the Chairperson of the Board, such disclosure shall~~Such disclosure shall be in addition to disclosure previously or concurrently made ~~to the Vice Chairperson of the Board. Such disclosure shall be in addition to disclosure previously or concurrently made~~ on any annual statement.
2. A person seeking to make a disclosure may also disclose to the Corporate Compliance Officer of ECH.
3. All persons are encouraged to disclose situations where they are uncertain whether a potential conflict of interest exists so that a determination can be made under the process described below.

COPY

E. **Procedure for ~~Dealing with~~Addressing a Potential Conflict of Interest:**

1. Individual is not a Board Member
    a. The individual must disclose the facts giving rise to the interest to the key manager(s) in charge of the proposed transaction or arrangement. If the individual seeking to disclose is unsure as to whom to report, such person shall contact the Corporate Compliance Officer.
    b. If the proposed transaction or arrangement requires Board approval or if the individual is in charge of the proposed transaction or arrangement, then the interest and all material facts must be disclosed to the Chief Executive Officer, the Corporate Compliance Officer ~~and~~or Chief Legal Officer or such person's immediate supervisor.
    c. After disclosure, the immediate supervisor of the person making the disclosure, or the key manager in charge of the transaction (assuming the key manager does not have an interest) or the Corporate Compliance Officer (the Corporate Compliance Officer can involve the Chief Executive Officer), shall determine whether the interest creates a potential conflict of interest. If a potential conflict of interest exists, they shall take appropriate steps to mitigate or eliminate the effect of the potential conflict of interest on the proposed transaction.
    d. The immediate supervisor, the key manager(s), and/or Corporate Compliance Officer (the Corporate Compliance Officer can involve the Chief ~~Executive~~Legal Officer), shall determine the action(s) to be taken

with respect to the interest. Actions may include (but are not limited to):

i. Exclusion of person with the conflict of interest from negotiating or evaluating the transaction or arrangement

ii. Exclusion of the entity or individual in which the person has a conflict of interest from the negotiation or selection process

iii. Seek alternatives to the proposed transaction or arrangement to ensure that it is in the best interest of the Hospital.

iv. Appropriate disclosure to the Board for a Board action, if necessary

e. The immediate supervisor of the person with the conflict of interest, the key manager in charge of the transaction, and the Corporate Compliance Officer or Chief Legal Officer shall prepare a memorandum describing the facts, the decision(s) and action(s) taken in addressing the conflict of interest.

f. The memorandum shall be filed in the files of the Corporate Compliance Officer and in the employee's personnel record. The Corporate Compliance Officer shall report to the Compliance and Audit Committee regarding the disposition of such matters and to the Board, as appropriate.

COPY

2. Individual is a Board Member or Board Advisory Committee Member

a. ~~In the event a Board member has an interest in a matter to be considered by the Board, the matter shall be reported to the Chief Executive Officer and referred automatically to ECH's Ad Hoc Interests Committee (defined below) for determination as to whether a potential conflict of interest exists. A Board member may recuse himself or herself from the matter, without further action, and the Board shall take such actions that shall be necessary to mitigate any potential conflict of interest as described below.~~

b. ~~If the affected Board member does not recuse himself or herself, the Chairperson or Vice Chairperson, as applicable, shall recommend to such Board member whether recusal or other action should be taken. If the Board member with the conflict of interest disagrees with such recommendation, then upon request, he or she shall be afforded the opportunity to discuss the issue with ECH's Ad Hoc Interests Committee, which shall have final authority in its sole discretion to determine whether a potential conflict of interest exists.~~

c. ~~The Ad Hoc Interests Committee shall be comprised of two Board members, neither of whom have an interest in the transaction or agreement. If only two Board members do not have an interest, such two Board members shall comprise the committee; if more than two Board members do not have an interest, the committee shall be comprised of the person without an interest who is the Chair, Vice-Chair, or Secretary of ECH (in that order) and a Board member without an interest with the longest tenure who is not an officer and who does not have an interest. Such committee shall be staffed by the Corporate Compliance Officer and legal~~

counsel to ECH.

d. In the event a Board or Board Advisory Committee member has an interest in a matter to be considered by the Board or Committee, the matter shall be reported to the Chairperson of the Board (or Vice Chairperson if the Chairperson has an interest), or the Chairperson of the Committee if involves a Committee matter (or Vice Chairperson of the committee if the Chairperson has an interest) and the Chief Executive Officer, the Corporate Compliance Officer and the Chief Legal Officer before the matter is considered by the Board or Committee. This groups shall constitute the "Ad Hoc Interests Committee". The Ad Hoc Interests Committee shall obtain information from the interested Board or Committee member and may obtain advice from other sources, including outside counsel, the FPPC or Attorney General if appropriate to assist in determining whether there is a potential conflict of interest.

e. The Ad Hoc Interests Committee will make recommendations for appropriate actions including but not limited to:
   - Exclusion of person with the conflict of interest from participating in the matter before the Board or Committee;
   - Seeking alternatives to the proposed transaction or arrangement to ensure that it is in the best interests of the Hospital;
   - Refer the matter to the full Board for disclosure and appropriate action;
   - The transaction or arrangement involving a conflict of interest may proceed only if it is determined by a majority vote of disinterested board members that the transaction is fair and reasonable; and/or
   - Other appropriate mitigating actions.

f. If the interested affected Board or Committee member disagrees with the Ad Hoc Interests Committee, or the Ad Hoc Interests Committee refers the matter to the full Board, the Board or Committee member shall be given an opportunity to disclose all material facts to the full Board. After disclosure of the financial interest and material facts, and after any discussion with the interested Board or Committee member, the interested Board or Committee member shall leave the meeting while the determination of a conflict of interest is discussed and voted upon by the Board. The Board shall seek the advice of the Corporate Compliance Officer and the Chief Legal Officer.

g. The Corporate Compliance Officer and Chief Legal Officer Counsel shall, before each Board or Committee meeting, review each matter scheduled to be considered by the Board or Committee at its next Board or Committee meeting and the annual disclosure statement (and any updates) filed by each Board or Committee member. If aRegardless of the annual disclosure statement, Board and Committee members have a separate responsibility to disclose conflicts before and during a meeting to

COPY

the Chairperson of the Board or Committee. If a Board or Committee member has disclosed an interest that relates to a matter that will be considered by the Board or Committee, the Corporate Compliance Officer or Chief Legal Officer shall notify the Board or Committee member, with a copy to the Chief Executive Officer, the Chairperson or the Vice Chairperson of the Board and of the Committee, as appropriate. In order to avoid a situation where Board or Committee matters are deferred, persons bringing matters before the Board or Committee shall give prompt notice to the Corporate Compliance Officer or Chief Legal Officer of matters that are likely to be considered by the Board or Committee at upcoming meetings so that as much time as possible is permitted to identify and resolve any potential conflicts prior to the Board or Committee Meeting.

h. If a Board or Committee member is uncertain whether a conflicting interest exists and whether such interest must be disclosed, a Board or Committee member may seek advice on whether a conflict exists and whether additional disclosure or action is necessary. A Board member may consult with an advisory group consisting of two or more of the following individuals: Corporate Compliance Officer~~,~~ and Chief Legal ~~Counsel, external advisor(s) as determined by the Compliance Oversight Committee, and Chief Executive~~ Officer.

COPY

i. ~~Depending on the subject matter, the Corporate Compliance Officer will be the lead advisory member to manage the process. Should the Corporate Compliance Officer also have a potential conflict, then a prompt meeting of the Compliance Oversight Committee will be called to appoint the lead advisory group member and determine additional appropriate advisory group member(s).~~Depending on the subject matter, the Chief Legal Officer will be the lead advisory member to manage the process or determine if additional advisors or agencies should review or if the Ad Hoc Interests Committee should be convened.

j. After discussing the details of the potential conflict of interest with the ~~advisory group member(s)~~Corporate Compliance Officer and Chief legal Officer and gathering the facts and analysis, the ~~advisory group member(s)~~Corporate Compliance Officer and Chief Legal Officer will make a written recommendation.

    i. If the decision is that no additional inquiry is needed and no conflict exists, then the matter will be considered closed, and the Chief Compliance Officer will log the consultation in the Compliance Activity log ~~and copy each Board member~~.

    ii. ~~If the matter requires further fact gathering, then the advisory group member(s) will conduct further inquiries to determine whether further action by the Board is required.~~

    iii. ~~If the decision is that a disclosable conflict exists, then the advisory group member(s) will include in the report recommendations for mitigation of the effect of the potential conflict for the Chairperson or designee to consider.~~

iv. If the matter requires further review or action, the Ad Hoc Interests Committee will be convened to proceed per this policy.

k. ~~If, after the foregoing process, a Board member must disclose the interest to the Board, then the following must be included in the process:~~

~~i. The Board member must disclose the existence and nature of the interest and all material facts to the Board when considering the proposed transaction or arrangement. The Board member shall also respond to all questions posed by the Board regarding the potential conflict of interest.~~

~~ii. If the Board member's interest is substantial enough to create a conflict of interest, then the Chairperson or Vice Chairperson acting as the Chairperson for purposes of taking action on the actual or potential conflict of interest shall determine how to mitigate the effect of the interest on the decision being made. The affected Board member may ask that the matter be referred to the Ad Hoc Interests Committee.~~

~~iii. Prior to making the decision, the Chairperson or Vice Chairperson shall seek the advice of legal counsel, other Board members, and/or any of the advisory group member(s).~~

l. Mitigating the effects of potential conflicts:

i. Since each case will have unique circumstances, the ~~Chairperson or designee, the~~ Ad Hoc ~~Interests~~Interest Committee or ~~the advisory group~~Board shall apply the following criteria:

- The Chairperson or Vice Chairperson shall request that such Director: (1) leave the room during all or part of the related presentations and discussions, and (2) refrain from participating in all or part of the related presentations or discussions. In all circumstances involving an actual or potential conflict of interest, the Chairperson or designee and the Board shall require the interested person to refrain from voting on any matters related to the actual or potential conflict of interest.
- The Board shall determine whether ECH can obtain a more advantageous transaction with reasonable efforts from a person or entity that does not involve a conflicting interest. If a more advantageous transaction is not reasonably attainable under the circumstances, the Board may approve the transaction only if it determines, by a majority vote of the other Board members who do not have a conflict, that:
    - The transaction is in ECH's best interest and for its own benefit; and

COPY

- The transaction is fair and reasonable to ECH.

ii. ECH may purchase services from any corporation, association, trust, partnership, firm, venture or other entity of which any person subject to this policy is a trustee, officer or employee or owns equity, proprietary or beneficial interest.

iii. ~~Notwithstanding~~However, notwithstanding the foregoing, ECH shall not purchase services from any other corporation, association, trust, partnership, firm, venture or other entity of which a Board member is a trustee or officer or in which a Board member owns more than 5 percent equity, proprietary or beneficial interest unless:

- The purchase decision is made pursuant to a bidding process; or
- The purchase involves an expenditure by ECH in the aggregate of less than $50,000; or
- The services are provided pursuant to a contract with a term of one year or less.

iv. In taking action on behalf of ECH, the Board shall include its findings as part of the motion being adopted~~,~~ and record such resolution in the minutes of the meeting.

v. Unless not reasonably practicable prior to entering into the transaction, any transaction involving an actual or potential conflict of interest shall be addressed by the Board and not by a committee of the Board. If, in an urgent situation, the transaction is approved by a committee, the transaction shall be submitted to the Board at its next meeting. The transaction must then be ratified by a vote of the majority of disinterested Board members.

vi. Transactions involving Board member(s) must follow all additional requirements under California Corporations Code § 5233 not stated in the policy~~ as then in effect (see Appendix A)~~. In addition, District Board Members are subject to the requirements of the California Political Reform Act and Goverment Code section 1090.

F. **Situations Disclosed by Others:**

1. If any person has reasonable cause to believe that a person has failed to disclose an interest relating to a transaction (the "Individual"), the person with the information shall provide such information to the Corporate Compliance Officer or the Compliance Hotline, disclosing all related facts.
2. In the event of any such disclosure, the Corporate Compliance Officer shall conduct a factual investigation, including interviewing the Individual about whom the

COPY

disclosure is made, informing the Individual of the allegations and providing a full opportunity to explain the circumstances. The Corporate Compliance Officer shall determine whether a disclosing of the identity of the Individual making the allegation is permitted by law and is warranted in the circumstances.

3. The Corporate Compliance Officer shall inform the Individual of the results of such investigation and afford the Individual an opportunity to explain any alleged failure to disclose or any other fact relating to the allegations.
4. Upon considering the Individual's response, the Corporate Compliance Officer shall make such further investigation as warranted by the circumstances.
5. If the Corporate Compliance Officer tentatively determines that the individual has failed to disclose an interest, the Corporate Compliance Officer shall recommend to the Individual's supervisor, the Chief Human Resource Officer and the Vice President ~~for Human Resources and the Vice President~~ of the affected division appropriate corrective actions including termination of employment, contract, or privileges at ECH.
6. If the situation involves a Board or Committee member, appropriate corrective ~~action~~actions may be taken per applicable policies and as specified under California Corporations Code § 5233. The affected Board member shall ~~follow the process as specified under California Corporations Code § 5233 as then in effect. The affected Board member shall~~ have the opportunity to request that the Ad Hoc Interests Committee (described above) be involved in the process, as described above.

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

COPY

Attachments

Annual COI Disclosure Statement 2025.pdf

Approval Signatures

Step Description	Approver	Date
Compliance Board	Diane Wigglesworth: VP, Compliance	Pending
	Diane Wigglesworth: VP, Compliance	12/2024

El Camino Health

Conflict of Interest
Annual Disclosure Statement

El Camino Health is committed to avoiding conflicts of interest and/or the appearance of conflicts as described in our Conflict of Interest policy, to comply with State and Federal regulations and maintain federal tax emption status.

An individual may not use their position within El Camino Health for personal financial interest or gain, advantage their personal interest in the outcome of an ECH decision, or to assist others, including family members, in profiting in any way at the expense of El Camino Health.

Return completed statement to the Compliance Department
Compliance@elcaminohealth.org
Contact the Compliance Department with any questions regarding completion of this statement at (650) 940-7032 or the email above.

Name: ________________________________

Position(s) you hold (check the appropriate box):

☐ Board Member or Board Committee Member

☐ Director / Manager

☐ Executive / Vice President

☐ Employee

☐ Medical Staff Chief / Vice Chief

☐ Volunteer

☐ Medical Director

☐ Contractor

☐ Other (Specify): ____________________

I hereby disclose the following information (including information regarding family members*). If you have nothing to disclose, please indicate by checking that box. Attach additional pages as needed.

- ***Family Member:*** defined as a person's spouse or domestic partner, siblings and their spouses, parent, grandparent, and great-grandparent, children and their spouses, grandchildren and their spouses, great-grandchildren and their spouses, and any other person living in the same household as the person subject to this policy.
- ***Reporting Period:*** Report as of the date of filing and any activities occurring within the preceding **Fiscal Year**, including activities that are no longer active. Indicate within the description if the activity is no longer held or active.

If you are uncertain whether to disclose an interest, please seek advice of Compliance and Legal Counsel. All applicable responses will be reviewed according to policy and a determination will be made on mitigating the effect of the interest, where possible.

El Camino Health

Conflict of Interest
Annual Disclosure Statement

Financial interest	☐ Nothing to disclose

Report for yourself, and family member (defined above), any ownership, equity, compensation, or any other financial interest that you have in an individual or entity of the type that:

a) El Camino Health transacts business with;
b) is seeking to conduct business with El Camino Health; and/or
c) is in direct competition with El Camino Health.

You **do not** have to disclose:

a) Stock held in companies that are publicly traded (e.g., on a national exchange), if you own less than 1% of all outstanding shares.
b) Investments you may hold by or through a diversified mutual fund, exchange traded funds or other similar diversified investment vehicles provided that you do not have control or influence over the investment decisions made by these funds.
c) Investments you hold in a 401k, 403(b), 457(b) and other retirement vehicles.

Compensation or Employment Arrangement	☐ Nothing to disclose

Report the full name of vendor or organization that provides you or a family member with compensation of any type if that vendor or organization is the type that:

a) El Camino Health transacts business with;
b) is seeking to conduct business with El Camino Health; and/or
c) is in direct competition with El Camino Health

This includes positions where you are an officer, director, employee, contractor, or consultant.

Conflict of Interest
Annual Disclosure Statement

Position of influence	☐ Nothing to disclose
Report any positions outside of El Camino Hospital that you or a family member have that are perceived as being a position of influence, paid or unpaid, such as service on a Board of Directors of another organization, any governmental affiliations, or other arrangements not reported above.	

Intellectual Property Rights	☐ Nothing to disclose
Report any patents, copyrights, or royalties owned or received by you or a family member.	

Involvement in Clinical Research Services	☐ Nothing to disclose
Report any healthcare clinical research trials in which you or a family member is the principal investigator, or has a supervising, contracting or budgeting role. You **do not** need to report on this form circumstances where the research is being conducted by El Camino Health.	

Use of Confidential Information for Personal Gain	☐ Nothing to disclose
I hereby certify that neither I, nor a family member, has disclosed or used, confidential information relating to El Camino Health's business for the personal profit or advantage of myself or my family (except such information as has been publicly disclosed or is publicly available), except as listed below.	

El Camino Health

Conflict of Interest
Annual Disclosure Statement

Gifts, Gratuities, and Entertainment	☐ Nothing to disclose
Report for yourself or family member any business gifts of travel reimbursements (e.g., lodging, transportation, and food) from any individual or entities that are of the type that: a) El Camino Health transacts business with; b) is seeking to conduct business with El Camino Health; and/or c) is in direct competition with El Camino Health Include the name of the organization, description and value of the gift, and the purpose of the gift. You **do not** have to include gifts, gratuities, and entertainment received from El Camino Health, family members, or relatives. If you received more than one gift from a single source, you'll add the value of those items.	

Any Other Activity or Interest	☐ Nothing to disclose
Report any other activity or interest that may be or may be perceived to be a potential conflict of interest. Please see Conflict of Interest policy for additional information.	

Certification:

I hereby certify that this document accurately and completely describes, to the best of my knowledge and belief, all financial and other interests, which are required to be reported under State and Federal Law and under the provisions of the ECH Healthcare Conflict of Interest Policy. I will update my Conflict of Interest disclosure statement should a material change occur during the year. I will also separately disclose any interests in connection with a specific transaction or arrangement that I am involved in per the Conflict of Interest policy.

Signature: ______________________________ **Date:** ____________________

If filling out form online, type name above. If filling out form online, type date above

Status Pending PolicyStat ID 16788447

Origination	03/1993	Owner	Aletha Fulgham: Dir Diagnostic Imaging Svcs
Last Approved	N/A	Area	Imaging Services
Effective	Upon Approval	Document Types	Policy
Last Revised	09/2024		
Next Review	3 years after approval		

Radiation Safety - Personnel and Medical Staff Monitoring and Dosimetry

COPY

COVERAGE:

All El Camino Hospital staff, medical staff, and volunteers

PURPOSE:

To provide a means of monitoring occupational radiation exposures affecting ECH personnel and contractors and provide a standardized process of oversight for all medical center dosimetry accounts and utilization.

POLICY STATEMENT:

All persons employed by El Camino Hospital and medical staff members must wear a dosimeter if they are working or observing in a controlled environment where ionizing radiation is present and are likely to receive a dose in excess of 10% of the annual occupational dose limits in a year from sources external to the body. The following is the procedure by which this monitoring is accomplished.

REFERENCES:

1. American College of Radiology – Radiation Safety
2. CA Department of Public Health
3. Title 17, California Code of Regulations, section 20.1201
4. Nuclear Regulatory Commission-Title 10, Code of Federal Regulations, Part 20

5. Policy: Declared Pregnant Radiation Worker

PROCEDURE:

~~A. Badge Assignment~~

A. Dosimeter/ Radiation Badge Assignment

1. El Camino Hospital is contracted with a radiation dosimeter monitoring service.
2. Service is initiated by providing the first and last name, birth date or last four digits of the Social Security Number for the individual requesting the dosimeter. If the person has previously held a dosimeter either here at El Camino Health or elsewhere, the entire Social Security number must be provided to ensure continuity of records.
3. Radiation dosimeters are exchanged monthly. Dosimeters are received and distributed by the Imaging Services Department to all departments who use them on a regular basis. Subaccount managers or their designee are responsible for distributing the dosimeters to individuals in their department.
   a. Prior month's dosimeters are to be collected and sent back to the company for interpretation each month. Each dosimeter holder is responsible to ensure their dosimeter is available for processing ~~by~~before the 5th of the month. If the dosimeter is not available to the subaccount manager by this time, the dosimeter is considered unreturned. Those who fail to return their dosimeters as required may be subject to progressive discipline.
   b. Subaccount managers or their designee are responsible for returning dosimeters to the Imaging department by the 5th of the month or the following Monday. Subaccount managers or their designee are responsible for reconciling returned dosimeters with that month's dosimeter packing list ***prior*** to returning badges to Imaging. For any unreturned or unused badge(s), subaccount managers or their designee, will provide written documentation as to the reason for the missing or unused badge(s) and include this documentation with the returned badges.
   c. Badges returned after that month's batch has been mailed will be held for shipment with the next month's badges.
   d. Badges returned after one (1) year will not be sent to the radiation dosimeter monitoring service.
   e. Spare badges are available upon request for employees and physicians as needed. A spare can be requested from MV or LG Imaging Control or by completing the dosimeter request form located on the toolbox here: Dosimeter Request Form
   f. The dosimetry monitoring service will provide monthly reports, which are reviewed by the Radiation Safety Officer ~~upon receipt~~.
4. Personnel whose exposure exceeds ALARA (As Low as Reasonably Achievable) limits are notified by the Radiation Safety Officer or his designee. Recommendations follow ECH ALARA guidelines as outlined within the Radiation Protection Program and correspond with the State of California Department of Public Health Services Radiation Control Regulation, Title 17.

COPY

~~B. Agencies, Vendors, Visitors, etc.~~

B. Agencies, Vendors, Visitors, etc.

1. Any visitors, vendors, physician observers, outside agency personnel and/or students, should wear their own dosimeter, which are to be provided by their place of employment or school.
2. If not provided by outside source, the hospital will issue a dosimeter to any individual whose anticipated dose is expected to exceed 10% of the annual dose limit while at the facility.

~~C. Proper Use of Dosimeters~~

C. Proper Use of Dosimeters

1. The tab at the top of the dosimeter labeled "Remove" should not be removed until ready for use. This tab will denote whether the dosimeter was used or unused. This allows tracking of unused badges for compliance monitoring.
2. Dosimeters are to be worn as instructed by the Radiation Safety Officer. Dosimeters shall be worn outside of personal protective shields except for fetal monitoring badges which are worn underneath the radiation protective shield.
3. Those individuals that work on both campuses should have separate dosimeters for each site. Dosimeters are not to be taken between campuses.
4. Those individuals routinely working with radioactive materials will wear a ring dosimeter in addition to the whole body dosimeter.
    a. Hand exposures are measured on those individuals that dispense nuclear pharmaceuticals and on request by individuals that may have consistent exposure to radiation of the hand.
5. Dosimeters should be left in the hospital after the worker has completed their day's activity to maintain consistent and accurate readings.
    a. Proper on site storage of dosimeters is provided by the hospital.
    b. This holder is to be stored in an environment that is limited to local background radiation exposure to ensure the integrity of the dosimeter.
6. As per policy **Declared Pregnant Radiation Worker Policy**, a fetal monitoring badge will be made available to the employee once a pregnancy is declared. See policy for more information on this process and proper use of the fetal dosimeter.
7. Dosimeter holder may be subject to disciplinary action for non-compliance of this policy, subject to HR and MEC policies.

~~D. Exposure Records~~

D. Exposure Records

1. In compliance with Title 17, monthly and cumulative records of exposure are available to the employee during their term of employment at El Camino Hospital.

COPY

2. Exposure records of all El Camino Hospital employees are available to future and concurrent employers ~~by a written signed release from the requesting employee~~.
3. When dosimetered employees leave the organization, they may complete a written release and provide their personal email so their final dose may be emailed to them once their last dosimeter readings are available.
4. With the exception of high radiation risk workers, or those with specific regulatory requirements for dosimeter monitoring, whose primary work duties put them at increased risk of radiation exposure, personnel may be considered for removal from the vendor list. Should any previously badged person wish to reinstate their dosimeter, he/she may do so by contacting the subaccount manager or designee.
5. Personnel whose badge readings are "M" (minimal) for 6 consecutive months have the option to no longer receive a monthly personal dosimeter. The RSO and their direct supervisor or manager will need to approve this change, and a Dosimeter Declination Form must be completed. Exceptions are high radiation risk workers, or those with specific regulatory requirements for dosimeter monitoring whose primary work duties put them at increased risk of radiation exposure.
6. All ALARA and overexposure records will be communicated to badge holders ~~within 10 days~~in a timely manner of receipt of such records. In the event of a significant overexposure, approaching Nuclear Regulatory Commission limits, the badge holder will be notified verbally. If the radiation safety committee is not in possession of current contact information, HR or the medical staff office will be contacted to obtain current contact information for purposes of notification.
7. Monitored staff are made aware of their dose records at least on an annual basis.
8. The Radiation Safety Committee and Radiation Safety Officer reserve the right to discontinue dosimeters based on prior dose history and occupational criteria.

COPY

Attachments

A. Dosimeter Declination Form
B. Authorization to Release Occupational Radiation Exposure History

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

Attachments

8138 Rev 04_2021 Auth to Realease Occupational Radiation Exposure History non NCR.pdf

Dosimeter Declination Form

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Department of Surgery	Patrick Santos: Policy and Procedure Coordinator	10/2024
Department of Surgery	Aletha Fulgham: Dir Diagnostic Imaging Svcs	10/2024
Radiation Safety	Joni Ballin: Administrative Coord	10/2024
	Aletha Fulgham: Dir Diagnostic Imaging Svcs	09/2024

COPY

History

Draft saved by Fulgham, Aletha: Dir Diagnostic Imaging Svcs on 9/26/2024, 11:47AM EDT

Edited by Fulgham, Aletha: Dir Diagnostic Imaging Svcs on 9/26/2024, 12:14PM EDT

> Minor changes to timelines.

Last Approved by Fulgham, Aletha: Dir Diagnostic Imaging Svcs on 9/26/2024, 12:14PM EDT

Comment by Ballin, Joni: Service Line Project Coordinator on 9/26/2024, 3:51PM EDT

> Emailed to RSC for approval

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 9/27/2024, 3:49PM EDT

Last Approved by Ballin, Joni: Service Line Project Coordinator on 10/8/2024, 11:04AM EDT

> Approved at 10/4/24 RSC

Last Approved by Fulgham, Aletha: Dir Diagnostic Imaging Svcs on 10/10/2024, 4:07PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 10/23/2024, 11:11AM EDT

> Surgery Exec 10/23/24

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/12/2024, 11:22AM EST

> ePolicy 11/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 11/21/2024, 1:28PM EST

> MEC 11/21/24

COPY

Status Pending PolicyStat ID 16942887

Origination	05/1995	Owner	Julee Arbuckle: Clinical Mgr
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval	Document Types	Scope of Service/ADT
Last Revised	11/2021		
Next Review	3 years after approval		

Cardio Pulmonary Wellness Center : Scope of Service

COPY

COVERAGE:

El Camino Hospital Cardiac Pulmonary Wellness Center

PURPOSE:

To describe the Cardiac & Pulmonary Wellness Center Unit and Scope of Services

PROCEDURE:

A. General Unit Description

1. The unit provides space for exercise equipment, education instruction and staff office space.
2. The staff includes a Medical Director for cardiac rehabilitation (CR), a Medical Director for pulmonary rehabilitation (PR), a Clinical Manager, CR registered nurses, PR registered nurses, exercise physiologists (EP), respiratory therapists (RT), and and an Administrative Assistant.
3. Supervisory coverage is provided by the Medical Directors, and the Clinical Manager during hours of operation. In the manager's absence, a CR or PR nurse will be designated in charge. (See Policy and Procedure Organization Chart, and Unit Job Description Binder.)

B. Services Offered

1. The CR client population exercise in an outpatient, supervised individualized exercise program. Monitored clients are on continuous telemetry while exercising.

Unmonitored clients are provided with telemetry monitoring based on medical necessity. Graduates of these programs are referred to appropriate community partners as requested. Reports to all clients physicians are sent upon request .

2. Clients in the CR program are admitted by physician referral with diagnoses of coronary artery disease, myocardial infarction, open-heart surgery, PCI-percutaneous coronary intervention, stable angina, valve repair/replacement and heart transplant and specific categories of heart failure. Clients are also considered for diagnosis of arrhythmia, hypertension, congestive heart failure or pacemaker implantation. Many may have co-morbid conditions of aging such as musculoskeletal conditions, diabetes, hypertension, hyperlipidemia, hearing and vision problems.
3. Clients are admitted into the program for various lengths of stay based on medical necessity. One hour classes meet on Monday, Wednesday and Friday scheduled throughout the day. Intake interviews and an orientation are scheduled before the first session of exercise. Educational lectures addressing cardiac risk factors are held on Wednesdays after the exercise session.
4. The Women's Heart Support Group is a community service for women living with coronary artery disease.
5. The client population of the Pulmonary Rehabilitation program consists of patients that participate in a closely supervised outpatient instructional and exercise conditioning program. They are monitored by oximetry and vital signs, and, if warranted, telemetry.
6. Clients in the PR program are admitted by physician referral with a diagnosis of COPD, chronic Bronchitis, bronchiectasis, persistent asthma, interstitial lung disease, cystic fibrosis and pre and post lung transplant with documentation of decreased pulmonary function. Many have co-morbid conditions of aging such as heart disease, HTN, arthritis, hearing and vision problems.
7. The average length of stay for PR patients is based on medical necessity. Classes meet Tuesdays and Thursdays. Each session includes didactic instruction and exercise. Intake interviews are completed prior to program entry.
8. Exercise Maintenance classes are one hour sessions of exercise. Clients are graduates of the PR classes with special need who are not yet appropriate for transition to independent exercise.
9. The Better Breather's Club is a community service for individuals living with pulmonary disease. The group meets once a month. A Better Breather's Newsletter is delivered to all members.
10. The Mycobacterium Avium/ Interstitial Lung Disease Support Group is a community service for individuals living with pulmonary disease. The group meets quarterly.

C. Meeting/Committees:

1. Formal staff meetings are held on a quarterly basis and more frequently as needed. There is a unit representative on the following committees: Safety Committee, Central Partnership Council, Patient Care Leadership Meeting, Peer Review, and Nursing Research Council.

COPY

D. Problem Resolution:

1. Problems with patients and clients are solved on an individual basis at the time of complaint. If resolution is not achieved the chain of command will be followed, first to the Clinical Manager, then to the Director of Critical Care Services, then to the Director of Clinical Quality and Patient Safety, Director of Risk Management and Patient Safety and finally to the Chief Nursing Officer.
2. Client medical safety issues are resolved at the time of occurrence by the clinical staff, consulting the appropriate Medical Director, and/or client's physician. If no resolution, the client may not participate in the exercise program. Medical Rounds are held weekly with medical directors.
3. Staff Problems will be resolved at the time of occurrence. If no resolution, the chain of command will be followed from Clinical Manager to Director of Critical Care Services and finally to the Chief Nursing Officer.
4. Physician problems will be resolved at the time of occurrence. If no resolution, the Medical Director will be consulted, the Programs Manager, Senior Medical Director for Physician Services, or Chief Medical Director.
5. Hospital problems will be resolved in an interdisciplinary manner at the time of occurrence using the appropriate resources.

COPY

E. Communication

1. Communication in the unit will occur on an ongoing basis via personal communication, emails, staff meetings and voice mail.

F. Staffing

1. Staffing for CR and PR will always include at least one RN for monitored clients and an EP, or RT with ACLS training to maintain appropriate staff ratios. Average staff to client ratio is 4:1 but may vary for both CR and PR programs; and 10:1 for CR and PR maintenance programs. Staff may be increased based on patient acuity. Intake interviews will be assigned only to staff trained in the process. One PR or CR staff is required for supervision of the support groups.

G. Orientation

1. All new staff will have general hospital orientation. Orientation to the unit will last for a period up to four weeks. Orientation will include: equipment set up, telemetry set up, oxygen monitoring and delivery systems, entering charges in the EHR, providing emergency care, locating unit procedures in the toolbox, reviewing the unit manual, reviewing phone voicemail system, staff schedules, reviewing the intake interview, outcome measurement process, and quality control measures, conducting warm-up/cool down exercises, monitoring exercise sessions, recognizing the physiological signs of exercise intolerance, reviewing educational content and materials, patient referral and evaluation system including registration process, and adapting techniques for clients with special needs.
2. Orientation to the CR program will include interpreting exercise prescriptions for clients, recording patient progress in the different phases of the program, using the computerized telemetry charging system, interpreting ECG strips, reviewing

individual treatment plans, risk factor reduction lectures, patient and physician follow-up communication, women's heart support group.

3. Orientation to the PR Programs will include, planning and scheduling sessions, recording patient progress, individualized treatment plans, computerized charting system, monitoring of exercise programs, maintenance of oxygen delivery systems, and knowledge of the various components of the pulmonary programs including the Better Breather's Club Support Group and Newsletter, and Mycobacterium Avium/ Interstitial Lung Disease Support Group.

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Department Medical Director or Director for non-clinical Departments	Julee Arbuckle: Clinical Mgr	10/2024
	Julee Arbuckle: Clinical Mgr	10/2024

History

Sent for re-approval by Arbuckle, Julee: Clinical Mgr on 10/24/2024, 1:31PM EDT

> none needed at this time

Last Approved by Arbuckle, Julee: Clinical Mgr on 10/24/2024, 1:31PM EDT

Last Approved by Arbuckle, Julee: Clinical Mgr on 10/24/2024, 1:32PM EDT

> Medical Directors approved and UPC approved 10/14/2024

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/12/2024, 11:20AM EST

> ePolicy 11/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 11/21/2024, 1:27PM EST

> MEC 11/21/24

COPY

Status **Pending** PolicyStat ID **17020505**

Origination	08/2015	Owner	Beth Willy: Director Clinical Education
Last Approved	N/A	Area	Scopes of Service
Effective	Upon Approval	Document Types	Scope of Service
Last Revised	09/2021		
Next Review	3 years after approval		

Scope of Service - Clinical Education Department

COPY

Types and Ages of Clients Served

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

Scope and Complexity of Services Offered

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

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

- Consulting with managers and staff to best decide the focus and implementation of education.

Staffing

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

Level of Service Provided

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

Standard of Practice

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

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

COPY

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Department Medical Director or Director for non-clinical Departments	Beth Willy: Director Clinical Education	11/2024
	Beth Willy: Director Clinical Education	11/2024

History

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 11/6/2024, 2:13PM EST

Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator on 11/6/2024, 2:14PM EST

> Updated approval worfklow; removed HR, per email from Beth Willy since they don't report to HR, but to Nursing Services. No changes to content.

Last Approved by Willy, Beth: Director Clinical Education on 11/6/2024, 4:15PM EST

> approved

Last Approved by Willy, Beth: Director Clinical Education on 11/6/2024, 4:15PM EST

> approved

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/12/2024, 11:19AM EST

> ePolicy 11/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 11/21/2024, 1:27PM EST

> MEC 11/21/24

COPY

Status Pending PolicyStat ID 16893820

Origination	05/2016	Owner	Gretchen Suess: Manager Palliative Care
Last Approved	N/A	Area	Patient Care Services
Effective	Upon Approval	Document Types	Policy
Last Revised	10/2024		
Next Review	3 years after approval		

End of Life Option Act Policy

COPY

COVERAGE:

All El Camino Hospital employees and medical staff.

PURPOSE:

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

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

POLICY STATEMENT:

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

Copyright © 2024 El Camino Health

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

COPY

DEFINITIONS:

1. **Aid-in-dying drug**: a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his her death due to terminal disease.
2. **Attending physician**: physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.
3. **Consulting physician**: a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

PROCEDURE:

A. The End of Life Option Act applies only to adults age 18 years or older. All such adult patients may be provided with educational materials regarding end-of-life options to the degree the patient desires and at the patient's request.

B. ~~When a patient makes an inquiry about or requests access to activities under the Act, the~~

Copyright © 2024 El Camino Health

~~patient should be referred to the Palliative Care Department. The Palliative Care Department is able to assist patients in understanding the requirements of the Act, inform them about the process and provide educational material related to the patient's end of life options. This activity will augment, but not substitute for, the obligations of the attending and consulting physicians' roles. If the patient's physician chooses not to participate in the Act, which is his or her right under the law, Palliative Care can assist in the identification of an appropriate resource.~~

C. Any patient, family member, surrogate decision maker, employee, independent contractor, medical staff, or volunteer may contact Palliative Care for ~~assistance~~general information. An inpatient Palliative Care consult order should be placed for patient specific questions regarding goals of care and End of Life Option Act.

D. Support is also available as needed from Spiritual Care Department and the Ethics Committee.

E. Patients who have met all obligations and all criteria as described in the Act, and desire to ingest "aid-in-dying drug" yet cannot be discharged from the hospital for an extenuating circumstance, will be evaluated on a case-by-case basis by a multi-disciplinary team of physicians, nursing, care coordination, Palliative Care as available, and Risk Management or Legal to develop an acceptable plan of care for the patients/family.

F. Discussions and care conferences with patients and families regarding the End of Life Option Act are to be documented in the electronic health record (EHR).

G. Risk Management and/or Legal should be contacted prior to an ECH provider providing an ECH patient a prescription for an aid in dying drug in an ECH outpatient clinic to ensure that all appropriate processes have been followed and documentation completed.

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

COPY

REFERENCES:

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

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

Approval Signatures

Step Description	Approver	Date
Board	Tracy Fowler: Director Governance Services	Pending

Copyright © 2024 El Camino Health

MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
	Gretchen Suess: Manager Palliative Care	10/2024

History

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 10/14/2024, 5:54PM EDT

Draft saved by Suess, Gretchen: Manager Palliative Care on 10/15/2024, 3:05PM EDT

Edited by Suess, Gretchen: Manager Palliative Care on 10/15/2024, 3:05PM EDT

> Deleted section B. Amended section C to request an order for inpatient palliative care consult for patient specific questions.

Last Approved by Suess, Gretchen: Manager Palliative Care on 10/15/2024, 3:05PM EDT

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/12/2024, 11:17AM EST

> ePolicy 11/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 11/21/2024, 1:25PM EST

> MEC 11/21/24

COPY

Copyright © 2024 El Camino Health

Status Pending PolicyStat ID 17027847

Origination	10/2008	Owner	Raquel Barnett: Sr. Director Medical Staff Services
Last Approved	N/A	Area	Medical Staff
Effective	Upon Approval	Document Types	Policy
Last Revised	08/2020		
Next Review	3 years after approval		

Medical Staff Code of Conduct and Professional Behavior

COPY

COVERAGE:

El Camino Hospital Medical Staff and Allied Health Clinicians

PURPOSE:

The purpose is to ensure a safe, cooperative, and professional health care environment that will ensure optimum patient care and prevent or eliminate (to the extent possible) conduct defined as disruptive or unacceptable behavior as defined below in IV B.

POLICY STATEMENT:

It is the policy of the Medical Staff of El Camino Hospital that the physicians and allied health practitioners treat all individuals within its facilities with courtesy, respect, and dignity. To that end, the Board of Directors requires physicians and privileged licensed practitioners will conduct themselves in a professional and cooperative manner in all El Camino Health facilities and understand and agree to adhere to a code of conduct and professional behavior. New and current practitioners of the El Camino Hospital Medical Staff will sign an acknowledgement of receipt of this policy at the time of appointment and reappointment, respectively.

DEFINITIONS:

A. **Acceptable behavior** is defined as behavior that enables others to perform their duties and responsibilities effectively, promotes the orderly conduct of the organization, and results in respectful and constructive communication. Examples of acceptable behavior include, but are not necessarily limited to:

1. Demonstration of dignity, respect, courtesy, cooperation and presentation of a positive and professional image when dealing with all patients and coworkers.
2. Respectful communication in a calm and professional manner.
3. Addressing disagreements professionally, factually and timely.
4. Communication with department and intradepartmental team members that is accurate and timely.

B. **Disruptive or inappropriate behavior** is defined as behavior that disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, physicians, allied health practitioners, patients or other individuals. The Medical Staff will not tolerate disruptive behavior, which may include but is not limited to:

1. Rude, vulgar or abusive conduct, verbal and/or physical, toward, or in the presence of, patients, nurses, hospital employees, other practitioners or visitors.
2. Non-constructive criticism or disparagement addressed to, or about, a recipient in a way as to intimidate, belittle or to infer stupidity or incompetence.
3. Impertinent and/or inappropriate comments written or illustrated in the patient's medical records or other official documents that impugn the quality of care in the hospital or malign particular practitioners, employees or hospital policy.
4. Deliberate destruction or stealing of hospital property, including medical records.
5. Disrupting hospital case management, committee or peer review functions.
6. Disrupting hospital personnel's ability to perform their assigned functions.
7. Refusal to accept medical staff assignments when required or refusal to participate in committee or departmental affairs in a professional and appropriate manner.
8. Harassment by a medical staff or Allied Health Staff member against any individual (other medical staff member, Allied Health Staff member, hospital employee, patient or visitor) on the basis of race, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, age, religion, or sexual orientation.
9. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment may include, but is not limited to, unwelcome advances, requests for sexual favors, and any other verbal, visual or physical conduct of a sexual nature when 1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion or other aspects of employment; or 2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.

COPY

REFERENCE:

~~California Business and Professions Code 805.8~~

~~Adverse Event Reporting to Regulatory or State Licensing Agencies Procedure~~

~~Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act, specifically Government Code §12940(a), (h) and (i), and the Ralph Civil Rights Act~~

- California Business and Professions Code 805.8
- Adverse Event Reporting to Regulatory or State Licensing Agencies Procedure
- Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act, specifically Government Code §12940(a), (h) and (i), and the Ralph Civil Rights Act

PROCEDURE:

A. Reporting and Initiation of Complaint. Any physician, allied health practitioner, employee, patient, or visitor may report potential unprofessional conduct of a medical staff member through the following channels: submission of an incident report or communication with hospital or medical staff leadership which can be verbal, by email, in writing or in person.

B. The report shall be forwarded to the Quality, Safety and Risk Department for documentation. Such documentation shall include:

    1. The date, time, and place of the questionable behavior.
    2. A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient.
    3. The circumstances that precipitated the situation.
    4. A factual and objective description of the questionable behavior.
    5. The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations.
    6. A record of any actions taken to remedy the situation including the date, time, place, and name(s) of those intervening.

C. Investigation:

    1. Once a report of unprofessional behavior regarding a medical staff member is reported, the matter will be referred to the Chief Medical Officer or his/her designee to investigate the incident. Investigation should include discussion with involved medical staff member and others as deemed appropriate. The medical staff member shall have a full opportunity to respond to the concerns during the entirety of the investigative process. The Chief Medical Officer or designee shall make a determination of whether the incident requires any action.
    2. If no further action is required, then the Chief Medical Officer or designee shall document this outcome and file that in the practitioner's quality file.
    3. Initial collegial intervention will be informal among the provider and the campus and department specific vice chair. A copy of this policy will be provided, the need for

COPY

compliance will be emphasized and the discussion documented in the practitioner's Quality file along with a simple email that will be sent to the provider. A communication of such meeting shall be delivered to the appropriate Department Chair.

a. In the spirit of an informal collegial intervention, an administrative representation in the meeting with the practitioner may be present only at the discretion of the campus and department specific vice chair

4. Level 1 is defined as an apparent or recurrent incidence of disruptive behavior. If the single incident is egregious and/or the incident along with past events signifies a developing pattern of disruptive behavior, the Chief Medical Officer designee and the Department specific Chair will meet with the practitioner to discuss the next intervention. They will provide the practitioner with a copy of this policy and inform the practitioner that the Board requires compliance with the policy and failure to comply shall be grounds for summary suspension.

   a. The Chief Medical Officer designee or one the Department specific Chairs shall document this meeting and write a follow up letter to the practitioner to document the content of the discussions and the actions that the practitioner has agreed to perform with possible ramifications of compliance failure. This letter shall be kept on file

COPY

5. Level 2 is defined as a persistent pattern of disruptive behavior and will be addressed by the Leadership Council. The practitioner will be present at the time that the behavior is discussed. Appropriate recommendation will be recommended.

   a. Involved practitioner may submit a rebuttal to the charge which will also be kept in the practitioner's quality file

   b. Documentation of the discussion will be contained in the Leadership Council minutes

   c. Documentation of the discussion will be placed in the practitioner's file with a certified letter sent to the practitioner of the recommendations

6. Level 3 is defined as a single egregious behavior and/or a persistent pattern of disruptive behavior despite prior counsellings. The matter will be referred to the MEC for review. Possible actions include:

   a. Development of a behavior contract setting zero tolerant goals for the practitioner or

   b. Recommending other appropriate actions in accordance with the Medical Staff Bylaws, including possible Summary Suspension, to the Board of Directors

7. c. Appropriate documentation shall be entered in the practitioner's file

D. Conclusions

1. If the Single Incident is egregious, then move to Level 3

Incident or Pattern	Administrative	Medical Staff
Single Incident	Optional	Campus and Department Specific Vice Chair
Level 1	CMO designee	Department Specific Chair
Level 2	Leadership Council	Leadership Council
Level 3	MEC	MEC

COPY

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

Attachments

Code of Conduct - Acknowledgement of Receipt

Approval Signatures

Step Description	Approver	Date

Board	Tracy Fowler: Director Governance Services	Pending
MEC	Michael Coston: Director Quality and Public Reporting [PS]	11/2024
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	11/2024
Medical Staff Leadership Committee	Raquel Barnett: Sr. Director Medical Staff Services	11/2024
	Raquel Barnett: Sr. Director Medical Staff Services	11/2024

History

Comment by Carson, Catherine: Senior Director Quality on 9/24/2020, 6:01PM EDT

> MEC on 9/24/20 removed the Medical staff from the ECH Discrimination and Harassment procedure. As a result, we needed to add that the medical staff must also adhere to Title VII of the Civil Rights Act of 1964, the California Fair Employment and Housing Act, specifically Government Code §12940(a), (h) and (i), and the Ralph Civil Rights Act regulations (which cover sexual harassment and violence in the workplace.

Draft saved by Santos, Patrick: Policy and Procedure Coordinator on 11/7/2024, 1:13PM EST

Sent for re-approval by Santos, Patrick: Policy and Procedure Coordinator on 11/7/2024, 1:13PM EST

> Initiating review

Approval flow updated in place by Santos, Patrick: Policy and Procedure Coordinator on 11/7/2024, 1:15PM EST

Last Approved by Barnett, Raquel: Sr. Director Medical Staff Services on 11/7/2024, 1:23PM EST

Last Approved by Barnett, Raquel: Sr. Director Medical Staff Services on 11/7/2024, 1:28PM EST

Comment by Santos, Patrick: Policy and Procedure Coordinator on 11/7/2024, 1:36PM EST

> Leadership Council 11/12/24

Last Approved by Santos, Patrick: Policy and Procedure Coordinator on 11/12/2024, 11:02AM EST

> ePolicy 11/8/24

Last Approved by Coston, Michael: Director Quality and Public Reporting on 11/21/2024, 1:24PM EST

> MEC 11/21/24

COPY

Status **Pending** PolicyStat ID **16938523**

Origination	04/1998	Owner	Christine Cunningham: Chief Experience and Performance Improvement Offic
Last Approved	N/A	Area	Patient Rights
Effective	Upon Approval	Document Types	Policy
Last Revised	11/2024		
Next Review	3 years after approval		

Patient Rights

COPY

COVERAGE:

All El Camino Hospital staff

PURPOSE:

To outline patient rights and responsibilities identified by state, federal and Joint Commission regulations and standards.

STATEMENT

It is the policy of El Camino ~~Healthcare~~Health to respect a patient's rights and to inform ~~all~~ patients or their designated representative of their patient rights. If a patient has designated a patient representative, the patient representative shall be able to exercise the same rights as would the patient. The patient/patient representative has the right to exercise these rights without regard to sex, race, color, age, religion, ancestry, national origin, disability, medical condition, marital status, sexual orientation, educational background, economic status, the source of payment for care, gender identity/expression, registered domestic partner status, genetic information, citizenship, primary language or immigration status (except as required by federal law).

PROCEDURE:

A. All ~~Patients~~patients (~~inpatients~~inpatient/outpatient) receiving services at El Camino Health shall have notice of their Patient Rights.

B. A patient has the right to designate another person to serve as his/her representative either

orally or in writing and that person shall receive notice of the patient's rights. The patient's designation of the representative shall continue throughout the inpatient stay or outpatient visit unless the patient requests differently.

1. If the patient is incapacitated, staff shall identify the appropriate representative for notification. The following hierarchy shall be observed when identifying the patient representative:
    a. Whether the patient has an advance directive or other written designation by the patient identifying the patient's representative.
    b. Whether the patient has available family members who are able to make decisions for the patient. This includes spouses, domestic partners, and parents. If more than one family member asserts that s/he is the patient's representative and there is no advance directive
2. If there is confusion with identifying who the appropriate patient representative is, staff shall consult with Risk Management. The final decision regarding designation of the patient's representative and the hospital's rationale shall be documented in the medical record. A refusal to treat an individual as the patient's representative shall also be documented in the medical record along with the specific basis for refusal.

C. Patient Rights are posted in the required public facing areas of the hospital and outpatient departments / areas in Spanish and English ~~and Spanish in public facing areas of the hospital and outpatient departments / areas in Spanish and English~~ in accordance to regulatory guidelines. ~~Patients~~If a patient needs the Patient Rights ~~information~~in another language, other than Spanish or English, an appropriate interpreter will be called. If patient is ~~also made available on the hospital website and included in the inpatient handbook as well as inpatient admission folder. If a patient needs the Patient Rights in another language or needs assistive devices such as hearing or~~ visually impaired, ~~an appropriate interpreter should~~accessible format will be ~~called~~made available.

D. Along with Patient Rights and Responsibilities, included are phone numbers which patients, family and / or caregivers may call to ask for assistance in resolution of conflicts regarding care.

REFERENCES:

1. The Joint Commission
2. Title 22, Section 70707 Patient's Rights
3. CMS Code Section 1288.4; 42CFR Section 482.13 and 42 CFR 489.102
4. Federal Register/Vol.75, No. 223, November 19, 2010/Rules and Regulations

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

Attachments

COPY

Derechos Del Paciente

Patient Rights

Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	Pending
	Christine Cunningham: Chief Experience and Performance Improvement Offic	11/2024

COPY

Status **Pending** PolicyStat ID **16857924**

Origination	11/2020	Owner	Poopak Barirani: Asst Director Pharmacy
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval	Document Types	Plan
Last Revised	06/2023		
Next Review	1 year after approval		

MERP - Medication Error Reduction Plan

COPY

COVERAGE:

El Camino Hospital Mountain View & Los Gatos

MERP (Medication Error Reduction Plan) OVERVIEW:

In 2001 the California legislature passed legislation resulting in HSC 1339.63 which required every general acute care hospital to adopt a formal plan to eliminate or substantially reduce medication-related errors. Ensuring that our patient population receives quality health care is and always has been of utmost importance to El Camino Hospitals.

Medication error reduction is one of our key areas of focus. This plan is an opportunity to evaluate our strategies for safe medical practices related to professional practice, or health care product, procedures, and systems, including, but not limited to, prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.

This plan outlines multiple methods for reducing medication errors and will address each of the following strategies:

- Evaluate, assess, and include a method to address the 11 elements: prescribing, prescription order communications, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use to identify weaknesses or deficiencies that could contribute to errors in the administration of medication.

- Annual review of the plan to assess the effectiveness of the implementation of procedures and systems related to the 11 elements.
- Modify the plan as warranted when vulnerabilities or deficiencies are noted to achieve the reduction of medication errors.
- Evaluate and assess ability and progress in implementing information technology requirements and how technology implementation is expected to reduce medication-related errors.
- Include a system or process to proactively identify actual or potential medication-related errors. The system or process shall include concurrent and retrospective review of clinical care.
- Include a multidisciplinary process, including health care professionals responsible for pharmaceuticals, nursing, medical, information technology and administration to regularly analyze all identified actual or potential medication-related errors and describe how the analysis will be utilized to change current procedures and systems to reduce medication-related errors.
- Include a process to incorporate external medication-related error alerts to modify current processes and systems as appropriate e.g., ISMP and medication safety publications.

REFERENCE:

COPY

- SB1875 & HSC 1339.63(g)

OBJECTIVES:

- Create a common understanding of the current state of medication errors in the healthcare industry and to create a non-punitive system of reporting errors.
- Define medication processes that support medication safety throughout the 11 elements.
- Improve the clinical decision making process related to medication use.
- Improve communication among the health professionals and patients.
- Monitor Medication error events.
- Enterprise Medication Safety Committee, RN-RX Council MV and RN-RX Council LG and Pharmacy & Therapeutics Committee (P&T) review and evaluate various components of medication management: practices, processes, and usage, compliance and safety concerns.

STRUCTURE:

A. A collaborative multidisciplinary approach has been organized to ensure adequate participation of hospital personnel. Each of the following participate in the medication safety improvement process:
    1. care staff. Pharmacy and Nursing Leadership coordinate the meetings. The councils make recommendations, advise, and provide guidance and recommendations related to nursing practice and operationalizing initiatives. RN-RX reviews ISMP newsletters as part of the agenda. RN-RX is also the approving body for Automated Dispensing Machines (ADM) override requests.

2. Medication Safety Committee: The members of the committee include representatives of medical staff, pharmacy, nursing, and quality/patient safety and adhoc members. The committee is responsible for the evaluation and implementation of the MERP and reports directly to P&T. The Medication Safety Committee analyzes medication error reports, medication usage, medication shortages and participates in MERP. This is a committee that proposes action plans for process improvement and makes recommendations to P&T.
3. MERP subcommittee: The members include: Pharmacy, Nursing and other ad hoc members. MERP subcommittee will be directly working on the Medication Error Reduction Plan and will report to Medication Safety. Responsible for monitoring compliance and developing action plans related to 11 MERP elements.
4. Pharmacy and Therapeutics (P&T) Committee: Medical Staff Committee consisting of Physicians, Chief Nursing Officer (CNO), Senior Director of Quality , pharmacists, dietician, pharmacy informatics staff, nursing leadership and ad hoc members. P&T reviews a summary of medication error/event reports and adverse drug reactions, approves/monitors formulary deletions and additions, reviews recalls/medications in short supply, MERP plan, and approves policies and procedures.
5. Hospital Quality Committee & Patient/Employee Safety Committee: Medication Safety and Pharmacy Department reports medication safety activities to these committees.
6. Medical Executive Committee: Reviews P&T reports, reviews and approves policies and procedures.
7. Pharmacy Department: Review of medication use related to procedures and systems: prescribing, prescription order communication, product labeling, packaging and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use; medication errors.

COPY

B. Medication Error Reporting process:

1. Errors, near misses, safety and system issues are reported by hospital staff using the electronic system for reporting of unusual occurrence and patient safety issues.
2. The reports are reviewed by risk management and clinical leadership. Trends for medication errors will be identified and analyzed by Med Safety and MERP committee on a regular basis and takes actions as appropriate.
3. Medication error trends and MERP plans are reported to P&T for review and approval.
4. P&T refers physician specific issues to appropriate Medical Staff committees and process issues to Hospital Quality Committee as needed.

C. Communication of Medication Safety Information:

1. Staff and Department Meetings
2. Departmental or organizational newsletters such as Pharmacy Newsletter, and InTouch (nursing newsletter), Pharmacy-Nursing Connection Newsletter
3. Resources provided include computer based drug information programs (e.g.,

UpToDate, Micromedex/Lexicomp , as well as other available references in the intranet "Tool Box")

4. Policies and Procedures: Policies and procedures are available online on the hospital's intranet.
5. Director of Pharmacy sends monthly Nursing ISMP and biweekly overall Institute of Safe Medication Practices Acute Care Edition to all pharmacy and nursing staff.
6. External sources of information will be reviewed and shared with staff as appropriate. Examples of sources include but are not limited to the following: FDA Medwatch list serve, California State Board of Pharmacy list serve, The Joint Commission Sentinel Event Alert list serve, the ASHP Patient Safety News list serve, the Agency for Healthcare Research and Quality (AHRQ), and the Institute for Healthcare Improvement (IHI).

MEDICATION ERROR REPORTING AND MONITORING:

A. Definition: A "medication-related error" means any preventable medication-related event that adversely affects a patient and that is related to professional practice, or health care products, procedures, and systems, including, but not limited to:
    1. Prescribing
    2. Prescription order communications
    3. Product labeling
    4. Packaging and nomenclature
    5. Compounding
    6. Dispensing
    7. Distribution
    8. Administration
    9. Education
    10. Monitoring
    11. Use

B. Proactive identification of actual and potential medication related errors:
    1. Medication Safety Committee: Continuous performance improvement review mechanism for medication errors both potential and actual. Reviews medication errors, performs regular assessments, and conducts ongoing evaluation of the medication systems and procedures.
    2. Identification of the potential medication-related errors are done by reviewing a variety of patient safety related publications such as ISMP Medication Safety Newsletter, FDA MedWatch, The Joint Commission Sentinel Event Alerts, ASHP Patient Safety List-Serve and California Board of Pharmacy e-mail alerts, identifying any issues that are pertinent at the facility and then implementing suggested

COPY

changes.

C. Voluntary Non-Punitive Reporting System:

1. Potential or actual medication-related errors are primarily identified via non-punitive unusual occurrence reporting system by hospital staff, which can be submitted anonymously.
2. Actual or potential (near miss) medication-related errors are identified by all staff and physicians.
3. Adverse Drug Reaction (ADR) reports may be done via unusual occurrence system, telephone hot-line or by pharmacy generating reports on reversal agents.

PROCESS:

A. Plan Development Process:

1. Multidisciplinary MERP subcommittee members evaluate the current plan and facilitate the assessment of MERP. Potential or actual medication errors and adverse medication events are discussed at Medication Safety Committee and then reported to Pharmacy & Therapeutics.
2. Analysis of Medication Errors: MERP sub-committee reviews medication errors to identify trends, categorize, and identified the opportunities for reductions of errors.
3. MERP Subcommittee is responsible for identifying annual goals for MERP.

B. Assessment:

1. Baseline assessment of medication related problems and annual review of the effectiveness of the plan are performed using an objective based critical review. If the plan is not effective in reducing medication errors, MERP will be revised to redesign actions to achieve goals.

C. Requirements for Assessing the Effectiveness of MERP:

1. Evaluate, assess, and include a method to address each of the procedures and systems listed under 1339, H&S, subdivision (d) to identify weaknesses or deficiencies that could contribute to errors in the administration of medications.
2. Categorize and focus on evaluating 11 elements of the MERP implementation for ongoing improvement.

Refer to ECH detailed Fiscal Year MERP Crosswalk (Medication Safety Committee)

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

Attachments

COPY

Final-FY2023-Medication Safety and MERP Annual Report

FY24 MERP - FY25 Goals

MERP FY2021 Annual and FY22 Plan.pdf

MERP Trends and Accomplishments FY2020

Approval Signatures

Step Description	Approver	Date
P & T Committee	Mojgan Nodoushani: Senior Manager-Clinical Pharmacy	Pending
Medication Safety Committee	Poopak Barirani: Asst Director Pharmacy	10/2024
	Poopak Barirani: Asst Director Pharmacy	10/2024

COPY

Status Pending PolicyStat ID 17134991

Origination	10/2015	Owner	Cheryl Reinking: Chief Nursing Officer
Last Approved	N/A	Area	Patient Care Services
Effective	Upon Approval	Document Types	Plan
Last Revised	11/2024		
Next Review	3 years after approval		

Plan for Provision of Nursing Care

COPY

~~COVERAGE:~~COVERAGE:

All El Camino Hospital staff

~~PURPOSE OF PLAN~~PURPOSE OF PLAN

El Camino Hospital's (ECH) plan for providing nursing care is designed to clearly outline the system of nursing practice utilized. The plan for providing nursing care supports both the Hospital's and Nursing's mission and philosophy, and is based on the needs of the patients and their families, the physicians, the interdisciplinary team, and the nursing staff.

~~MISSION STATEMENT~~MISSION STATEMENT

El Camino Hospital Nursing Services espouses the philosophy that the patient is at the center of its business. We are dedicated to providing the best healthcare possible to our patients. We believe in the dignity and respect of each patient as an individual. Nursing services exist to provide the professional practice of nursing to El Camino Hospital patients, as well as to assist in the coordination of all services delivered to patients.

~~DEFINITION OF NURSING~~DEFINITION OF NURSING

Nursing is the diagnosis and treatment of human responses to actual or potential health problems. Nursing is further defined as those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or

the treatment thereof, and that require a substantial amount of scientific knowledge or technical skill.

~~VISIONS FOR NURSING~~VISIONS FOR NURSING

- Decision making at the bedside. Managers as support to the staff.
- Support services at the point of care delivery, enabling nurses to stay at the bedside.
- Interdisciplinary approach to care planning and care delivery through patient-centered care coordination.
- Service excellence through selection, training, and system support. Service excellence depends on effective systems, technical skills and interpersonal skills.

~~NURSING PHILOSOPHY~~NURSING PHILOSOPHY

El Camino Hospital's Nursing Division is committed to excellence in patient care through competence, confidence and caring. We believe that:

- ~~El Camino Hospital's Nursing Division is committed to excellence in patient care through competence, confidence and caring. We believe that:~~
- Caring is the essence of nursing.
- Our patients and their needs are our central focus.
- ~~Each person is unique and is characterized by his/her own life patterns.~~
- ~~It is essential to consider the patient's age, nationality, race, creed, and cultural background in planning for and providing care.~~
- Every person is unique and brings their own life patterns, identities, and experiences. We acknowledge and respect each patient's age, nationality, race, beliefs, and cultural background, making these elements integral to our care planning and delivery.
- Individuals interact with their environment; therefore, patient care must reflect consideration for the psychosocial, spiritual and cultural variables that influence the perception of their illness.
- The influence of cultural, spiritual, and psychosocial factors, we provide care that respects and responds to the unique needs of diverse patients.
- Our patients have the right to live and die with dignity.
- Patient care is optimized when accountability for decisions and actions is shared between patient and caregivers.
- Patients, families and/or significant others contribute to the patient's well being.
- An environment with clear expectations of professional practice and established standards of care ensures optimal patient care.
- Quality patient care can best be provided in an atmosphere of continuing staff development, clinical research, and professional growth.
- Professional growth and staff development is a responsibility shared by the individual employee and the organization.
- Nursing is both an art and a science, a professional discipline that requires a sound education

COPY

and is grounded in its own research base.

- Nursing as a clinical discipline employs physiological, psychosocial, physical and technological means for human comfort, sustenance and improved well-being.
- We, as nurses, and our nursing colleagues have a right to be recognized and rewarded as professional practitioners.
- Patient care is enhanced by providing continuity of care through thoughtful patient assignments and relevant communication between caregivers.

~~RESPONSIBILITIES AND ACCOUNTABILITIES~~RESPONSIBILITIES AND ACCOUNTABILITIES

A. ~~**Registered Nurses (RNs)**~~Registered Nurses (RNs)

ECH RNs perform the following:

1. Assess patients' needs considering physiologic, cognitive, and psychosocial factors. Assessments specifically address age-specific needs, environmental factors, cultural factors, self-care ability, educational needs and discharge planning requirements before assigning care to other members of the healthcare team.
2. Involve the patient and the patient's significant others in determining patient care needs and nursing interventions.
3. Plan and coordinate patient care in collaboration with physicians, other clinical disciplines, patient and the patient's significant others. The planning and delivery of care shall reflect all aspects of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy with the initiation of these processes at the time of admission.
4. Educate the patient and significant others regarding specific health care needs of the patient.
5. Document initial assessments, reassessments, interventions, responses to interventions, outcomes of interventions, and the ability of the patient or significant others to manage continuing care needs after discharge.
6. Utilize standards of care and standards of practice in providing and supervising patient care.
7. Work collaboratively with the medical staff and other health care disciplines to carry out diagnostic and therapeutic functions related to the evaluation and treatment of patients.
8. Evaluate care by utilizing performance improvement monitoring activities based on patient outcomes.
9. Prescribe, administer, supervise, and evaluate nursing activities. Perform these functions within the parameters of his/her educational background, experience, cultural, and ethical values.
10. Perform their duties in compliance with all regulatory agencies and in compliance

COPY

with the Hospital's mission, goals, and policies and procedures.

11. Behavioral Health serves as the consultative liaison for crisis intervention services.
12. Assess the Social Drivers of Health for all patients

B. ~~Licensed Vocational Nurses (LVNs)~~Licensed Vocational Nurses (LVNs)
ECH LVNs, with direction from a RN, perform the following:

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Provide direct patient care.
3. Administer medications as allowed by the LVN practice act.
4. Demonstrate professional communication skills for the purpose of patient care, education, and multidisciplinary team collaboration.
5. Contribute to the development and implementation of a teaching plan related to self-care for the patient.
6. Perform their duties in compliance with all regulatory agencies and in compliance with the Hospital's mission, goals, and policies and procedures.

C. ~~Clinical Support (CS) Staff/Certified Nursing Assistants (CNAs)~~Clinical Support (CS) Staff/ Certified Nursing Assistants (CNAs)
ECH CS staff/CNAs with the direction from an RN perform the following:

1. Gather and document data.
2. Recognize and report abnormal data values.
3. Report data to the RN on a timely basis.
4. Assist patients in performing activities of daily living.
5. Actively collaborate with and take direction from the RN about the patient's plan of care.

D. ~~Administrative Support (AS) Staff~~Administrative Support (AS) Staff
ECH AS staff performs the following:

1. Provide clerical and communication functions.
2. Maintain a complete and accurate medical record.
3. Actively collaborate with all staff to promote efficient workflow within the unit and other departments.

E. ~~Administrative Support/Monitor Technicians (MTs)~~Administrative Support/Monitor Technicians (MTs)
ECH MTs perform the following:

1. Duties as outlined in D. above.
2. Monitor and interpret EKG rhythms and visual monitoring consistently and correctly.
3. Notify the RN of EKG changes or concerns.

COPY

F. ~~Licensed Psychiatric Technicians (LPTs), Dialysis Patient Care Technicians, ED Technicians, OR and L&D Technicians.~~
~~ECH~~ Licensed Psychiatric Technicians (LPTs), Dialysis Patient Care Technicians, ED Technicians, OR and L&D Technicians ~~with direction from a RN, perform the following:~~.

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Provide direct patient care
3. LPT may administer medications as allowed by the LPT practice act.
4. Demonstrate professional communication skills for the purpose of patient care, education and multidisciplinary team collaboration.
5. Contribute to the development and implementation of a teaching plan related to self-care for the patient.
6. Perform their duties in compliance with all regulatory agencies and in compliance with the Hospital's mission, goals, and policies and procedures.

G. ~~Behavioral Health Workers~~Behavioral Health Workers
ECH behavioral health workers, with direction from a RN, perform the following:

1. Use and practice basic data collection, participate in planning, execute interventions in accordance with the plan of care or treatment plan and contribute to evaluation of individualized interventions related to the care plan or treatment plan.
2. Demonstrate professional communication skills for the purpose of patient care, education and multidisciplinary team collaboration.
3. Contribute to the development and implementation of a teaching plan related to self-care for the patient.

COPY

~~AREAS WHERE NURSING IS PRACTICED~~AREAS WHERE NURSING IS PRACTICED

• ~~Acute Inpatient Areas~~Acute Inpatient Areas	• ~~Outpatient and Diagnostic Areas~~Outpatient and Diagnostic Areas
Acute Rehabilitation	Behavioral Services – Outpatient
Behavioral Health Services (Inpatient Psychiatry)	Cancer Center
~~Emergency Services~~	~~Cardio Pulmonary Wellness Center~~
Intensive & Critical Care Unit	~~Dialysis Services~~Cardio Pulmonary Wellness Center
Labor and Delivery (L&D)	~~Endoscopy~~Dialysis Services
Lactation Services	Emergency Services
Medical/Surgical/Ortho	~~Interventional Services~~Endoscopy
~~Mother/Baby~~	~~Outpatient Surgical Unit~~

Mother/Baby	Interventional Services
Neonatal Intensive Care Unit (NICU) Level II and Level III	Pre-op/ Short Stay Unit (2B)Outpatient Surgical Unit
Operating Room (OR)	Radiation OncologyPre-op/ Short Stay Unit (2B)
Ortho Pavilion	Radiation Oncology
Ortho PavilionPediatrics	Radiology Services (Imaging, Interventional, Nuclear Medicine, Ultrasound, MRI)
Pediatrics	Wound Care Center
Post-Anesthesia Care Unit (PACU)	Willow Pavilion Outpatient Surgery Center
Progressive Care Unit (PCU) (Stepdown)	Wound Care Center
Telemetry/Stroke	
• Other	
Care Coordination	
Employee Health	
Heart and Vascular Institute	

COPY

SCOPE OF SERVICESCOPE OF SERVICE

The scope of service which includes the types and ages of patients/clients served, assessment methods, scope and complexity of services, staffing/skill mix, level of service and standard of practice for each of the areas where nursing care is provided is included in the Department Specific Scope of Services Section of this document.

ORGANIZATION OF NURSING SERVICESORGANIZATION OF NURSING SERVICES

Nursing services has an organizational structure that maintains a close relationship among the CNO (Chief Nursing Officer), and the staff. This structure ensures that the CNO is aware of issues vital to quality patient care. The philosophy of nursing management is to promote a caring environment and to serve as support to the staff by continually improving patient care systems.

The CNO manages the quality of nursing practice across the organization. In addition, the CNO is responsible for directing the operations of the acute and specialty nursing units, the Assistant Hospital Managers (AHM) and /Hospital supervisors and Patient Care Resources/Staffing office, as well as other functions outlined in the job description.

Nursing directors report to the CNO and have responsibility for the fulfillment of the service's mission by the development and achievement of short and long term goals and objectives identified in the goal

setting process and working along with the medical staff, medical directors, and managers to provide the collaborative leadership necessary to achieve high quality, cost-effective, and integrated care. Clinical managers' report to a nursing director or to the CNO and have 24-hour responsibility for daily operations, as well as for the quality of care provided on one or more nursing units. The scope of this role includes, but is not limited to education, consultation, planning and administration.

Charge nurses are assigned each shift. ~~Nursing Unit Coordinators (NUC's) are assigned as permanent Charge RN's on some of the nursing units~~They report concerns to the Assistant Clinical Manager, Clinical Manager, and/or Assistant Hospital Manager/Hospital Supervisor.~~ They report concerns to the clinical manager and/or to the Hospital supervisor~~. Additionally, the charge nurses~~/NUC's~~ support the clinical managers in the operational/ management activities of the unit on a shift basis. If a unit has an Assistant Clinical ~~Managers and Nursing Unit Coordinators are present on some nursing units.~~ ~~They~~Manager, they report to the clinical manager or Director.

Care coordinators are accountable for specific patient populations and are experts in clinical care for those patients. They identify patients who require more intensive care coordination and work with the nursing staff to facilitate optimal patient outcomes. Care coordinators meet daily with staff from multiple disciplines to communicate issues and solve problems. Through daily meetings with staff, the care coordinators establish mechanisms that assist in the continuous improvement of care delivery, and they facilitate the coordination of a patient's care as the patient moves from one unit to another.

COPY

Care coordinators work closely with physicians, clinical managers, charge nurses and clinical nurses in the use of clinical patient goal attainment and in the management and coordination of care. Additionally, care coordinators set up case conferences to improve patient outcomes through collaboration with the health care team. Multidisciplinary rounds are held at least weekly on each inpatient care unit. Care coordinators are an integral part of these rounds.

Preceptors are selected on each unit to assist with integrating new staff into the ECH system of care. They also assist in the training of staff transferring from another unit or staff being cross-trained. Preceptors serve as clinical role models. They maintain their competency at a high level in order to be effective in demonstrating competencies as well as monitoring the competencies of staff new to the unit.

The CNO is ultimately responsible and accountable for the quality of nursing care throughout the organization. Responsibility for nursing care is retained by nursing services when students and agency nurses are providing the care.

On the off shifts, the Assistant Hospital Manager~~ and ~~/Hospital ~~supervisors~~Supervisors not only manage nursing services, but also serves as the representative for hospital administration. ~~He/she has~~They have the authority to make decisions, which relate to the acute functioning of all departments. The Assistant Hospital Manager~~ and ~~/Hospital ~~supervisor consults~~Supervisor consult other department managers/ directors, clinical managers, nursing director the CNO, the Administrator–On-Call, as needed with off-shift problems.

The Director of Clinical and Nursing Education, in collaboration with the CNO, coordinates with the schools of nursing. This coordination includes negotiation of contracts, determination of student

placement, planning of future student interactions, and problem resolution. The Director of Clinical Education, in collaboration and coordination with appropriate nursing personnel, is responsible for planning and directing orientation for nursing unit personnel.

~~STANDARDS OF COMPETENT NURSING PRACTICE~~STANDARDS OF COMPETENT NURSING PRACTICE

A registered nurse shall be considered to be competent when he/she/they consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

1. Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
2. Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
3. Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.
4. Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.
5. Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and the health team members, and modifies the plan as needed.
6. Acts as the client's advocate, as circumstances require by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.
7. Collects pertinent data related to health and quality of life in a systematic, ongoing manner, with compassion and respect for the wholeness, inherent dignity, worth, and unique attributes of every person, including but not limited to demographics, environmental and occupational exposures, social determinants of health, health disparities, physical, functional, psychosocial, emotional, cognitive, spiritual/transpersonal, sexual, sociocultural, age-related, environmental, lifestyle/economic assessments.
8. Consistent standards for provision of nursing care within the hospital are used to monitor and evaluate the quality and appropriateness of nursing care to meet patient needs. The nursing staff functions according to the general standards of care, standards of competent nursing practice, unit-specific standards of nursing practice, and other standards as specified in the hospital's policy and procedure manuals.

COPY

9. All responsibilities, functions, and/or competency checklists of the nursing staff are documented in job descriptions.
10. Interim permittees function at ECH in accordance with the regulation and the direction of the California Board of Registered Nursing. A permittee only practices under the direct supervision of a registered nurse and is only allowed to perform nursing functions taught in the permittee's basic nursing program.

~~GENERAL STANDARDS OF CARE~~GENERAL STANDARDS OF CARE

SCOPE: All areas of the hospital where nursing care is provided. "Patient" may include family/significant other, where appropriate.

- Patients can expect to receive care within a safe environment.
- During the hospital stay, patients can expect to receive information/education regarding the hospital, nursing units, procedures, medications, and plan of care, plus, information/education regarding continuing health requirements post-discharge.
- Patients can expect to receive communication in their preferred language regarding responses to the care, illness, and therapy.
- Patients can expect to receive care in a supportive environment that facilitates their gradual progress toward independence.
- Patients can expect assistance with activities of daily living (ADLs) if they are unable to perform them.
- Patients can expect to receive care with respect for privacy, individuality, and values.
- Patients can expect to receive information concerning their rights, responsibilities, resources, and options.
- Patients can expect to have effective management of pain.
- Patients can expect that their health care dollars will be managed to optimize/achieve their goals and that patients and their significant others will be involved in the plan of care.

NURSING UNITS MAY HAVE ADDITIONAL STANDARDS OF CARE SPECIFIC TO THEIR PATIENT POPULATION.

~~STAFFING~~STAFFING

A sufficient number of qualified RNs are on duty at all times to give patients the care that requires the judgment and specialized skills of a RN. Staffing is performed using staffing guidelines established from the previous budget year, anticipated patient volume and mix for the coming year and regulatory requirements. Historical data includes patient classification (nursing ~~intensity measurement~~workload scoring system) information, from patient and physician satisfaction measurement data, information from the performance improvement system and human resources, and complaints. Daily and shift staffing are adjusted based on assessment of patient nursing ~~intensity measurements~~workload score and staffing guidelines.

Plan for Provision of Nursing Care (cont)

Staffing is sufficient to assure prompt recognition of any untoward change in a patient's condition and to facilitate appropriate intervention. Additionally, the assigned RRT RN's respond to Rapid Response calls initiated by staff in the hospital (See Rapid Response Team Procedure)

There are certain types of rapid response calls based on the condition of the patient. A cardiac alert is called and a specialized team responds if a patient is experiencing chest pain (See Management of the Adult Patient with Chest Pain, Anginal Equivalent Symptoms, Possible Acute Coronary Syndrome, (In-House Cardiac Alert ProcedureA stroke alert is called when a patient is experiencing signs and symptoms of a stroke and a specialized team responds (see In-House Stroke Alert Procedure A sepsis alert is called when a patient is meeting the SIRS criteria for suspected sepsis (See Sepsis Alert, Adult, In-House and Emergency Department) An OB alert is called when an OB patient experiences a serious change in condition (OB AlertProcedure).

During regular business hours, the Assistant Hospital Manager/Hospital Supervisor is responsible for departments where conflicting needs arise/exist will resolve the conflict and direct staffing resources in a manner that best meets patient needs. Should the conflict not be resolved in this manner, the officer of the day will be responsible for making the final decision.

During other hours, the Assistant Hospital Manager/Hospital supervisor will be responsible for directing the staffing resources in the manner that best meets patient needs.

COPY

Staffing resources are evaluated at least annually and modified based on input from physicians, patients and staff. State mandated ratios are maintained on units where applicable. All regulations & processes related to ratio adherence are followed. In addition, new programs, patient populations, volume trends, performance improvement findings, and comparisons with other like facilities, as well as other factors are considered in determining staffing levels. Position control and recruitment & retention data are monitored at least quarterly by the CNO, nursing directors, and clinical managers with subsequent modifications made as indicated.

A patient classification system known as the Nursing Workload Scoring System (NWSS) is used to guide both planning and utilization of nursing ~~intensity measurement system (NIMS) is used to guide both planning and utilization of nursing~~ resources and to document trends in patients' nursing resource needs over time. ~~NIMS has five levels~~This patient classification system uses a score generated by the Nursing Workload Scoring System embedded in the electronic health record. The tool measures the level of care ~~with a range of~~that is expected to be needed during the next shift. The score is based on a multitude of rules that make up the total workload score for each patient, which includes but is not limited to activities of daily living, patient admission, assessments, discharges, wounds, ostomies, lines, drains, airways, medications, orders, and the patient's intensity of needs. Each year, the workload score ranges per unit and the appropriateness of the nursing hours of care ~~hours prescribed for~~assigned to each ~~level. The ranges were developed by the NIMS committee and a consultant. Each~~are reviewed by nursing and finance in determining the budget for the next year~~, the numbers of patients by level and the appropriateness of the nursing hours of care assigned to each level are reviewed by nursing and finance in determining the budget for the next year.~~.

Reliability of the ~~NIMS~~NWSS is performed annually and the reliability data is reviewed with nursing management and the ~~NIMS committee~~Direct Care Informatics Council.

In the event of positive variances (too many staff), employees may be required to "float out" to another unit with a negative variance to assist in the provision of patient care, to participate in taking mandatory time off/cancellation (hospital convenience [HC] time).

In the event of negative variances (too few staff), the following steps may be implemented to correct the variance:

1. Staff on duty with the required competencies may be floated from a unit with a positive variance to the unit where the negative variance occurs.
2. Regular and Per Diem staff not on duty will be called to determine their availability.
3. Volunteers to work overtime will be requested from appropriate staff.
4. Consideration will be given to relocation of patients(s) to another unit where capacity and adequate, trained staff is available, i.e. GYN patients to Maternity unit; Medical patients to Surgical unit, etc.
5. Consideration will be given to recall staff from off unit committee and educational programs.
6. Assign other appropriate nursing personnel to direct patient care duties, i.e. CNS, Nurse Educator, Clinical Manager, etc.

If the negative staffing variance cannot be corrected by the above actions, the following will be considered:

1. Divert new admissions from the understaffed unit(s).
2. Review OR, Cardiac Cath Lab at Mountain View, and L&D schedules for potential delay or cancellation of scheduled elective cases.

If staffing requirements exceed staffing available or bed capacity is insufficient, the Assistant Hospital Manager/Hospital Supervisor will alert the Charge Nurse in the OR, Cardiac Cath Lab at Mountain View and/or L&D. No cases will be allowed to proceed without the concurrence of the Assistant Hospital Manager/ Hospital Supervisor.

If cases are delayed, the AOC, Medical Director and procedural physician will be notified.

Early on each shift, Complex meetings are held enterprise wide in the Med/Surg/Critical Care and MCH regions to report and discuss current and anticipated departmental and patient care activity, any staffing variances for the present shift as well as predicted needs for the next shift, based on expected discharges, transfers and potential patient admissions including planned OR, Cardiac Cath Lab at Mountain View, Radiology interventional, and L&D scheduled cases. Staff attending Complex meetings includes the Assistant Hospital Manager/Hospital Supervisor, charge nurses, staffing office personnel and the Rapid Response Nurse at Mountain View, nursing unit Managers and Directors. Oftentimes, and especially during limited bed capacity, clinical managers, the manager of the Cardiac Cath Lab at Mountain View or designee attend the day shift meetings. Decisions regarding patient flow (admissions and transfers) are addressed as well as problem solving related to patient activity and staffing issues. During high census times and limited bed capacity, key participants of the Complex meeting may reconvene for an update and ongoing planning and problem solving based on the Peak Census Policy requirements. Additionally, the CNO or the Administrator On-Call (AOC) will be apprised of "critical" bed

COPY

shortages and real or potential cancellation of surgical and/or medical procedures.

Allocation of nursing resources allows for:

- Direct patient care activities
- Coordinating patient care given by nursing as well as other disciplines
- Communicating patient needs to other disciplines
- Participating in nursing, medical staff and hospital committees
- Participating in departmental/unit meetings and in-service education
- Participating in clinical practice standards development, review and revision, policy procedure development and performance improvement activities
- Training and orienting new personnel
- Receiving and acting on reports of committee Councils participating in assigned hospital/ departmental project work/activities

Assignments are commensurate with:

- Patient needs (degree of illness, stability and ability to care for self)
- Minimization of risk of infection
- Staff competency/expertise
- Medical regimen
- Unit geography
- Availability of support services
- Patient care delivery model
- Requirements for special nursing activities

COPY

RNs are assigned to the roles of:

- CNO
- Director
- Clinical Manager
- Assistant Hospital Manager/Hospital Supervisor
- Assistant Clinical Manager
- Charge Nurse
- Circulating Nurse
- Nursing Unit Coordinator/Clinical Nurse
- Preceptor
- ~~Care Coordinator~~Case Manager (Inpatient & Outpatient)
- Clinical Nurse ~~Specialists~~Specialist
- Nursing ~~Educators~~Educator
- Nurse Program ~~Coordinators~~Coordinator (e.g., Bariatric, Stroke, Oncology, etc.)

- Lactation Consultant
- Nurse SpecialistsSpecialist (e.g., Diabetes Educator, Wound and Ostomy RN, and Vascular Access RN.

SKILL MIXSKILL MIX

Nursing and other support services are performed by the following categories of personnel in the areas where acute inpatient/specialty nursing care is provided:

CCU/ICU	RN, Clinical Support (MV), Administrative Support (MV), Monitor Technician (LG)
PCU	RN, Clinical Support, Administrative Support
Telemetry	RN, Clinical Support, Administrative Support, Monitor Technician
Med/Surg/ Ortho/ Peds	RN, LVN, Clinical Support, Administrative Support (MV)
Psychiatry Services	RN, LVN, LPT, LCSW, OTR, Behavioral Health Worker, Administrative Support
Labor & Delivery	RN, , Administrative Support & OB Technician
Mother-Baby (MBU)	RN, LVN, Administrative Support
NICU/Level II and III	RN, LVN(MV), Administrative Support (MV)
Operating Room/IS	RN, Administrative Support, Surgical Technician, Operating Room Assistant (ORA), Interventional Technician
PACU	RN, Clinical Support
Endoscopy	RN, Endoscopy Technician
Pre-op/Short Stay/OPS	RN, Patient Registrar , Administrative Support, Clinical Support
Emergency Services	RN, Emergency Department Technician (MV), Administrative Support
Inpatient Dialysis	RN, ClinicalAdmin Support, Admin Support, Patient Care Technician
Acute Rehab (LG)	RN, Clinical Support, Admin Support

ADMISSION AND PATIENT FLOW PROCESSESADMISSION AND PATIENT FLOW PROCESSES

The Assistant Hospital Manager/Hospital supervisorSupervisor, , will coordinate all direct admissions/ transfers to the hospital. Through an interview process with the physician, or with his/her representative

COPY

or staff from another agency in the case of transfers in, the patient will be assessed to ensure proper placement within the hospital system. Placement decisions will be in collaboration with the unit charge nurses and are based on the patient's diagnosis, infection control issues, the patient's level of acuity and the department's admission, discharge and transfer criteria. Additionally, the availability of staff, staff competencies and unit environment will be considered, as well as patient and physician preference. Based on specific diagnoses, patients will be placed on their primary unit or alternate unit based on the above factors.

The patient assessment, obtained during the initial admission process, will be communicated to the nursing unit staff as well as to other appropriate departments, as appropriate. These departments include, but are not limited to: Care Coordination, Social Services, Physical Therapy, Occupational Therapy, Speech Therapy, Nutritional Services, Respiratory Medicine, Infection Control, and other ancillary departments, as needed. These referrals will be made to support the identified needs of the patient from pre-admission to post-discharge. Triggers for referral to services are identified in the following tables:

Triggers for Referral – TABLE A

~~**Triggers for Referral – TABLE A**~~
~~**(Data from initial Nursing Assessment; call appropriate department; document referral in patient record)**~~(Data from initial Nursing Assessment; call appropriate department; document referral in patient record)

~~***Care Coordination/Social Services:***~~ *Care Coordination/Social Services:* • Lives Alone • Homeless • Pt over 75 • Pt with chronic illness (i.e. COPD/ESRD) • Readmission w/in 14 days • Admitted from SNF • Known psycho-social problems • Pt requiring DME • Uninsured patients • Potential for complex discharge • CVA Diagnosis • Domestic/Elder/Child	~~***Diabetic Educator:* New dx of diabetes**~~ *Diabetic Educator:* New dx of diabetes • Knowledge deficit re: Diabetic Regimen • No financial resources for supplies or medical follow-up • Non-adherence to prescribed management plan. • Co-morbidities of hypertension or CAD • Admitted for diabetes out of control (DKA, Hank, Hypoglycemia • Admitted d/t diabetic related wound	~~***Rehabilitation Services***~~ ~~*These functional assessment elements require a MD order.*~~ ~~***Physical Therapy:***~~ *Rehabilitation Services* *These functional assessment elements require a MD order.* *Physical Therapy:* • *Automatic Triggers to PT: Orthopedic & Stroke Clinical Path; compression fx of spine • Gait/Balance problem • Recent falls
	~~***Nutrition Services:***~~ *Nutrition Services:*	~~***Occupational Therapy:***~~ *Occupational Therapy:*

Plan for Provision of Nursing Care (cont)

Abuse • Fetal Demise • Adoptions • New HIV diagnosis • Failure to thrive • Advance Directive follow-up • Hospice Service • Transportation Difficulties • Mother/newborn with positive drug screen	• Stage 3 or 4 pressure ulcer • *Recent weight loss/ gain due to illness • *Fluid restriction • *Special Diet • *Problems with eating: increased appetite, decreased appetite, nausea, difficulty swallowing, difficulty chewing, indigestion	• Unable to perform ADLs independently ~~***Speech Therapy:***~~ *Speech Therapy:* • New dx of aphasia • Impaired cognition • Impaired swallowing ~~***Palliative Care:***~~ *Palliative Care:* • Recent terminal disease diagnosis • Patient & family requiring end of life decision making • Patient & family struggling with CPR status decisions • Comfort Care Questions.
~~***Infection Control:***~~ *Infection Control:* • Positive AFB smears/ Suspected TB • Dx /suspected chicken pox/ shingles, influenza, measles, meningococcus, c-diff; MRSA, Pertussis, VRE, SARS, lice, scabies~~.~~, or other unique communicable disease	~~***Pharmacy:***~~ *Pharmacy:* • Pt. admitted with a medication related event (ADR or med error) • Pt. admitted with complex medication regime • Chronic pain history ~~***Pain Management:***~~ *Pain Management:* • Chronic pain history • Complicated pain	~~***Vascular Access Nurse***~~ *Vascular Access Nurse* • Order for PICC / Mid Line Placement

COPY

	• Medication regime	
~~***Wound and Ostomy Nurse***~~ *Wound and Ostomy Nurse* • *Braden ≤ ~~18~~18 • New or existing ostomy • Stage 3 or 4 pressure ulcer • Significant incontinence management problems • Stage 1 or 2 pressure ulcer	~~***Pastoral Care:***~~ *Pastoral Care:* • Pt. request for emotional/ spiritual support • End of Life Care • Fetal Demise	~~***Lactation Consultant:***~~ *Lactation Consultant:* • Failure to thrive infant of breastfeeding mothers • Lactating mother admitted with other medical problems • Postpartum difficulty with breastfeeding
Psychiatric Emergency Services: Emergency Department • Patients at risk for suicide • Patients with known mental health or addiction condition		

COPY

~~*Asterisk indicates automatic trigger generated by Electronic Medical Record reporting system; no need to call department/physician.~~

- Asterisk indicates automatic trigger generated by Electronic Medical Record reporting system; no need to call department/physician.

Triggers for Referral for Suspected Abuse – TABLE B

~~***Child Abuse***~~ *Child Abuse*	~~***Elder Abuse***~~ *Elder Abuse*	~~***Domestic Abuse***~~ *Domestic Violence / Intimate partner violence*	*Human Trafficking*
• Unexplained physical injury; physical injury not congruent with explanation • Sexual assault • Sexually	• Unexplained physical injury; physical injury not congruent with explanation • Sexual Assault • Malnutrition, dehydration, low albumin levels • Pt or family	• Repeated, unexplained physical injuries; physical injuries not congruent with explanation	• Someone speaking for the patient or refusing to leave the bedside. • Patient exhibiting fear, anxiety, PTSD, submission, or tension.

Transmitted Diseases in child <14 • Pregnant mother <16 and father >18 • No medical treatment for longstanding symptoms (medical neglect) • Severe malnutrition • Lack of clothing or shelter • Newborn suffering the effects of toxic substances ingested by mother • Newborn with positive drug screen	report of stolen or misappropriated money or property • Physical conditions indicative of poor hygienic care • No medical treatment for longstanding symptoms (medical neglect) • Altered mental status in which patient exhibits: fear, depression, confusion, or agitation	• Reported domestic violence by patient	• Patient reluctance to explain injuries or have inconsistency in story.

COPY

~~COMMITTEE STRUCTURE~~COMMITTEE STRUCTURE

The purpose of the Nursing Division committee structure is to provide a comprehensive and dynamic system that will contribute to meeting regulatory standards, support patient-centered care, and provide effective communication. The Patient Care Services Committee and task force structure will:

- Enable and promote staff involvement in decisions that affect clinical practice.
- Establish a mechanism by which registered nurses can evaluate standards of nursing practice, standards of care, and patient care delivery models, and make changes that will improve the quality and effectiveness of patient care and its outcomes within regulatory guidelines.
- Provide a system where staff, managers, and educators can come together for the implementation of Patient Care Services annual goals.

- Establish a forum in which health care disciplines can resolve system problems that may hinder the delivery of patient care.
- Provide multi-directional communication to ensure a uniform standard of nursing practice throughout El Camino Hospital.

~~***Standing Committees include:***~~**Standing Committees include:**

A. ~~**Nursing Directors Leadership Team Meeting**~~Directors Leadership Team Meeting

1. ~~**Membership**~~
   - ~~a. **Directors Reporting to the CNO**~~
     - ~~i. Director of Critical Care Services~~
     - ~~ii. Director of Cardiovascular Services~~
     - ~~iii. Director of Medical/Surgical Services~~
     - ~~iv. Director of Behavioral Health Services~~
     - ~~v. Director of Maternal Child Health~~
     - ~~vi. Director of Perioperative Services (MV))~~
     - ~~vii. Director of Nursing Services Los Gatos~~
     - ~~viii. Director of Care Coordination~~
     - ~~ix. Executive Director of Patient Experience~~

   Membership
   - a. Assistant Chief Nursing Officers (ACNO) and Directors in Nursing Services
     - i. ACNOs of Mountain View and Los Gatos Campuses
     - ii. Director of Behavioral Health Services
     - iii. Director of Cardiovascular and Critical Care Services
     - iv. Director of Care Coordination
     - v. Director of Clinical Business Operations
     - vi. Director of Clinical Education
     - vii. Director of Interventional and Emergency Services
     - viii. Director of Laboratory
     - ix. Director of Maternal Child Health
     - x. Director of Medical/Surgical Services
     - xi. Director of Patient Care Resources
     - xii. Director of Perioperative Services
     - xiii. Director of Respiratory Care
     - xiv. Magnet Program Director

2. ~~**Function**~~Purpose
   - a. Set team goals, objectives and priorities.

COPY

b. Champion, communicate, and clarify the vision, mission, core values, strategies, goals and priorities.

c. Align discipline/functional strategies, priorities, performance priorities, plans and performance expectations.

d. Allocate resources and management accountabilities for various resources.

e. Define and establish the culture based on the organization/team's core values.

f. Define discipline/functional, team and individual roles and accountabilities.

g. Develop and implement policies and procedures.

h. Ensure the diagnosis and resolution of organizational issues and challenges occur.

i. Define decision-making ownership and processes.

j. Facilitate the resolution of conflicts between service lines, units, departments, discipline/function or individuals that affect the organization's/team's ability to perform.

k. Develop successors and succession plans for leadership positions and career development opportunities/programs.

l. Champion and foster change and development efforts and initiatives.

m. Establish processes and activities that ensure thorough vertical and horizontal communication, collaboration, and decision making.

n. Serve as role models for the core values and related behaviors.

o. Achieve positive patient care safety and organizational results.

p. Set agenda for PCL meetings

3. Meeting Frequency/Minutes

a. Monthly

b. Minutes are disseminated to all members

B. ~~**Patient Care Leadership Council**~~Patient Care Leadership Council

1. ~~**Membership**~~Membership

a. CNO

b. ACNO

c. Nursing Directors

d. Clinical Managers

e. ~~Director Clinical Education~~

f. Assistant Clinical Managers

g. Assistant Hospital ~~Manager~~ Managers

COPY

h. Clinical Research Manager
i. Nursing Retention Specialist

2. ~~Function~~Function
    a. Serves as a forum for communication and discussion of hospital systems and policies that may impact nursing and other clinical services.
    b. Serves as a forum for communication and discussion of Nursing and other clinical services management concerns. This committee will allow for multi-directional communication, education and decision-making.
    c. Establishes structure standards for patient services.
    d. Serves as a forum for review and approval of Patient Care Policies.
    e. Initiates the annual goal-setting process, ensuring there is staff involvement and that the goals support the organization's mission and values.

3. ~~Meeting Frequency/Minutes~~Meeting Frequency/Minutes
    a. Scheduled to meet at least monthly or more frequently if necessary.
    b. Minutes are disseminated to all members. Copies of the minutes are maintained electronically by the Administrative Assistant.

C. ~~Central Partnership Council~~Central Partnership Council

1. ~~Membership~~Membership
    a. Direct Care Nurse (Chair)
    b. ~~Direct Care Nurse (Vice-Chair) The Vice-Chair will serve 1 year and then move into the position of Chair. Therefore, the length of term is a full 2 years; one as Vice-Chair and one as Chair~~Direct Care Nurse (Vice-Chair)
    c. Representatives from the Clinical Managers & ~~directors~~Directors from all areas nursing is practiced. ~~A manager/director from each service line will be chosen as a representative with one vote each. This appointment will rotate as determined by each service line~~
    d. Professional Development Council and Nursing Research Council representatives ~~with one vote each and length of service determined by council~~.
    e. Direct Care Nurse (DCN) representatives from all nursing units who represent their constituents from their unit ~~with one vote each and length of service determined by UPCs~~
    f. CNO
    g. Magnet Program Director
    h. Nursing Research Manager
    i. Nurse Retention Specialist

2. ~~Functions~~

COPY

- ~~a. A forum for DCN to communicate and collect ideas and feedback from other DCN's~~
- ~~b. Foster an environment that supports the reading and utilization of research to validate existing clinical practice or consider the need for change to improve the process or outcomes of care.~~
- ~~c. Provide feedback to the CNO regarding unit partnership Council decisions and discussions.~~
- ~~d. Review hospital wide quality and patient satisfaction data.~~
- ~~e. View presentations on evidenced based practice & research projects~~
- ~~f. A forum for sharing successes and opportunities for improvement~~
- ~~g. Input into budget planning~~
- ~~h. Input into clinical/nursing policy~~

Functions

- a. Serve as a collaborative forum for DCNs to share ideas, provide feedback, and communicate with peers and the CNO regarding unit partnership council decisions, discussions, and clinical/nursing policies.
- b. Review hospital-wide quality and patient satisfaction data, engage in evidence-based practice and research presentations, and foster an environment for utilizing research to validate or enhance clinical practices.
- c. Contribute to budget planning, share successes, identify opportunities for improvement, and support initiatives to improve care processes and outcomes.

COPY

3. ~~**Meeting Frequency/Minutes Processes**~~Meeting Frequency/Minutes Processes
   - a. Scheduled to meet monthly.
   - b. Meetings are made available to members and copies of minutes are available to all staff electronically by the Administrative Assistant for the CNO.
   - c. ~~On issues requiring a vote from the full membership; a consensus or majority vote will be used and declared at the time of the decision~~

D. ~~**Unit Partnership Councils**~~Unit Partnership Councils

1. ~~**Membership**~~Membership
   - a. Direct Care Nurse (chair).
   - b. Representatives from all classifications of employees who provide care on the unit.
   - c. CNS or Nursing Educator
   - d. Medical Director or physician representatives as available.
   - e. Clinical Manager
2. ~~**Functions**~~

a. ~~Define, develop, and evaluate the standards of nursing practice and standards of patient care specific to the unit and populations served.~~

b. ~~Make recommendations for modifications to patient care delivery, quality improvement activities, and support systems.~~

c. ~~Receive and disseminate information, findings, recommendations, and action plans to members, units, departments, and medical staff via their respective representatives.~~

d. ~~Reporting up on progress of unit based research projects~~

e. ~~Approval of unit based protocols and procedures~~

f. ~~Patient and staff safety issues are reported, discussed and action plans are developed.~~

g. ~~Budget input especially related to capital equipment purchases~~

Functions

a. Define, develop, and evaluate unit-specific standards of nursing practice and patient care, including approval of protocols, quality improvement activities, and recommendations for care delivery modifications.

b. Address patient and staff safety concerns by reporting issues, discussing them collaboratively, and developing actionable plans, while supporting unit-based research projects and ensuring effective dissemination of findings and action plans.

c. Provide input on budget-related matters, particularly capital equipment purchases, and facilitate communication across units, departments, and medical staff to align efforts and maintain high standards of care.

3. ~~**Meeting Frequency/Minutes Processes**~~Meeting Frequency/Minutes Processes
   a. Scheduled to meet monthly.
   b. Meeting minutes are made available to members and copies of meeting minutes are available on the unit to all staff.
   c. On issues requiring a vote from the full membership; a consensus or majority vote will be used and declared at the time of the decision

E. ~~**Professional Development Council**~~ Professional Development Council

1. ~~Clinical Nurse Specialists, Unit Nurse Educators, Program Coordinators, Staff members responsible for education in other clinical areas, representative from the Library and Resource Center, General Educator and Nursing rep from Information Systems. The Council is chaired by an elected member of the Committee.~~Membership
   a. Clinical Educators (Chair and Co-Chair)
   b. Clinical Nurse Specialists
   c. One of two direct care nurse (DCN) representative(s) per service line or campus

COPY

d. Magnet Liaison

e. Nursing Leadership Mentor (Clinical Education Director or designee)

2. The Professional Development Council supports Evidence Based Practice through oversight, developing standards, innovation, leadership and mentoring as related to education of staff, patients, families and the community of El Camino Hospital.Functions:

   a. The Professional Development Council supports Evidence Based Practice through oversight, developing standards, innovation, leadership and mentoring as related to education of staff, patients, families and the community of El Camino Hospital.

3. Meetings will occur onceMeeting Frequency/month and the minutes are taken by one of the co-chairs of the Council and are disseminated by the co-chairs of the Council.Minutes Processes

   a. Meetings will occur once/month and the minutes are taken by one of the co-chairs of the Council and are disseminated by the co-chairs of the Council.

F. **Nursing Research Council**Nursing Research Council

1. Members include staff members from each nursing unit in additional to selected management representatives, nurse educators, and CNS's. The Council is chaired by a Nursing Research Chair and elected co-chairs from members of the council.Membership

   a. Direct Care Nurse (DCN) from each nursing unit

   b. Clinical Manager Representative(s)

   c. Nurse Educator Representative(s)

   d. Clinical Nuse Specialists

   e. Program Coordinators

   f. Clinical Educator Director

   g. Nursing Leadership Mentor (Nursing Research Manager or designee)

2. The function of the NRC is to lead the implementation of evidenced based practice throughout the organization and to empower nurses with the skills and knowledge to understand and engage in nursing research. The overall mission of the Council is to promote a culture of inquiry that supports the purposeful use of evidence based nursing practice, which drives best individual patient care decisions to achieve high quality outcomes.Function

   a. To lead the implementation of evidenced based practice throughout the organization and to empower nurses with the skills and knowledge to understand and engage in nursing research.

   b. The overall mission of the Council is to promote a culture of inquiry that supports the purposeful use of evidence based nursing practice, which drives best individual patient care decisions to achieve high quality

COPY

outcomes.

3. Meeting Frequency/Minutes Processes
   a. Meetings will alternate every other month between virtual and real time.
   b. Minutes are made available to members and are copies of all meeting minutes are available to all staff.
   c. ~~Fifty-one percent (51%) of the occupied Council seats shall constitute a quorum for voting purposes. During the voting process, 51% of the present members must vote in favor of the proposed item. Voting will also be posed electronically and 51% must also vote in favor of the proposed item.~~

G. ~~**Direct Care Informatics Council**~~Direct Care Informatics Council

1. ~~**Membership**~~
   a. ~~Chair and optional co-chair~~
   b. ~~Representatives will be invited from the following inpatient divisions:~~
      i. ~~Acute Rehabilitation~~
      ii. ~~Behavioral Health~~
      iii. ~~Critical Care /Intensive Care/ Progressive Care~~
      iv. ~~Emergency Services~~
      v. ~~Information Technology~~
      vi. ~~Medical-Surgical~~
      vii. ~~Peri-operative Services~~
      viii. ~~Rehabilitation Services (PT/OT/Speech)~~
      ix. ~~Telemetry~~
      x. ~~Maternal Child Health~~

2. ~~**Functions**~~
   a. ~~Direct care clinical staff and Information Technology representatives work collaboratively to problem solve, select best practice, and improve workflow of the use of Health Information Technology. The goals of the council are to streamline, simplify, and standardize clinical documentation systems and processes to improve the safety, quality, and efficiency of patient care.~~
   b. ~~Participate in formal and informal consultations to address issues at the nexus of Nursing and Information Technology practice in healthcare.~~
   c. ~~Use evidence based practice and documented best practices when available to increase patient safety and improve the quality of patient care.~~
   d. ~~Advocate for the increased efficiency, and removal of ineffective, duplicative or otherwise counter-productive work when possible.~~
   e. ~~Review and offer subject matter expertise recommendations regarding the clinical documentation systems and workflows we use at El Camino~~

COPY

Hospital.

f. Support the Magnet model and goals, as well as applicable organizational goals and regulatory requirements.

g. Convey information to appropriate staff using communication formats that promote accuracy and accessibility.

3. Membership
   a. Chair and optional co-chair
   b. A representative from all inpatient nursing units
   c. A representative from information technology
   d. Nursing Leadership Mentor

4. Functions
   a. Collaborate with clinical staff and IT representatives to streamline, standardize, and improve workflows and documentation systems, enhancing patient safety, care quality, and efficiency through evidence-based practices and best practices.
   b. Provide expert consultation and recommendations on clinical documentation systems, advocating for increased efficiency by eliminating ineffective or duplicative tasks while aligning with organizational, regulatory, and Magnet goals.
   c. Promote accurate and accessible communication to convey information effectively across teams, ensuring alignment with healthcare standards and improving interdisciplinary collaboration.

5. **Meeting Frequency/Minutes Processes**Meeting Frequency/Minutes Processes
   a. Duration is ongoing and the frequency will be monthly for 2 hours
   b. The following will be used to communicate changes made by the committee:
      i. Present at shared governance groups including Central Partnership Council and Unit Practice Councils when appropriate.
      ii. Send out emails to our members directly and to larger groups of nurses as appropriate.
      iii. Disseminate communication to appropriate newsletters.

H. **Advance Practice Registered Nurse (APRN) Council**Advance Practice Registered Nurse (APRN) Council

1. **Membership** - The members of the APRN Council include APRN staff functioning as Nurse Practitioners and Clinical Nurse Specialists as well as an appointed representative from Administration. For professional growth, education and mentorship credentialed Nurse Practitioners and Clinical Nurse specialists are invited to join the APRN Committee.Membership -

COPY

a. APRN staff functioning as Nurse Practitioners and Clinical Nurse Specialists
b. Direct Care Nurses and Nurse Leaders holding an advanced practice nursing degree
c. Nursing Leadership Mentor

2. ~~Functions~~Functions
   a. Support APRN professional growth within the APRN Council
   b. Enhance communication and collaboration among other APRNs and other providers
   c. Identify opportunities to improve and standardize nursing practice to current evidence based practice
   d. Form partnerships with the other councils/committees
   e. Support annual promotion, implementation, and evaluation of the Evidence Based Practice Fellowship.
   f. Engage in mentorship activities for direct care nurses

3. ~~Meeting Frequency/Minutes Processes~~Meeting Frequency/Minutes Processes
   a. Scheduled to meet monthly for 1 hour.
   b. Meeting minutes are made available to members and copies of meeting minutes are available to all staff.
   c. Decision making is by consensus of a quorum members present, either by phone or proxy vote.

I. Peer Review Council
   1. Membership
      a. Direct Care Registered Nurses
      b. Nursing Research Manager
      c. Nursing Leadership Mentor (Magnet Program Director or designee)

J. Functions
   a. To disseminate peer review and peer-to-peer concepts that reflect best practice for quality and safety in delivery of patient care, and to provide an organized approach to implementation and evaluation of peer review or peer-to-peer efforts.
   b. Peer Review in nursing, as defined by the American Nurses' Association (ANA), is the process by which practicing registered nurses systematically assess, monitor, and make judgements about the quality of nursing care provided by peers as measured against professional standards of practice.

K. Meeting Frequency/Process
   a. Scheduled to meet monthly for 1 hour.
   b. Meeting minutes are taken and posted to shared folder by committee chair, co-chair,

COPY

or scribe (if applicable).

L. Clinical Manager Council

1. Membership
   a. ECH Clinical Managers
   b. Nursing Leadership Mentor (Magnet Program Director or designee)
2. Functions
   a. To achieve safe, efficient, effective care and a healthy work environment incorporating the El Camino Health core values and guiding principles of care into all decisions and activities regarding professional practice, quality and competence.
   b. Encourage communication, collaboration, and collegiality for creative and innovative decision-making.
   c. Participate in data collection and narrative development for the Magnet document.

M. Assistant Clinical Manager Council

1. Membership
   a. ECH Assistant Clinical Managers
   b. Nursing Leadership Mentor (Nurse Retention Specialist or designee)
2. Purpose
   a. To enhance nursing leadership, promote professional development, and improve patient care outcomes within the hospital.
   b. The council will serve as a platform for assistant clinical managers to collaborate, share best practices, and address challenges in nursing leadership.
3. Meeting Frequency/Process
   a. Scheduled to meet monthly for 1 hour.
   b. Meeting minutes are taken and posted to shared folder by committee chair, co-chair, or scribe (if applicable).

N. Coming Soon: Night Shift Council

1. Membership
   a. The council will consist of representatives from various nursing units and departments that operate during the night shift.
   b. Nursing Leadership Mentor (Nurse Retention Specialist or designee)
2. Purpose
   a. To enhance the experience and effectiveness of nursing staff working during the night shift.

COPY

b. The council aims to promote shared governance, improve communication and recognition, and address the unique challenges faced by night shift personnel, ultimately enhancing patient care and staff satisfaction.

3. Meeting Frequency/Process

a. Scheduled to meet monthly for 1 hour.

b. Meeting minutes are taken and posted to shared folder by committee chair, co-chair, or scribe (if applicable).

O. ~~**CNO Advisory Cabinet**~~CNO Advisory Cabinet

1. ~~**Membership** – The members of the CNO Advisory Cabinet are the chairs and vice chairs of all the shared governance councils including, Central Partnership Council, Professional Development Council, Nursing Research Council, Direct Care Informatics Council, Patient Care Leadership Council and Peer Review Committee. The CNO is the leader of the Cabinet meetings.~~Membership

a. Chairs and Vice Chairs of all the shared governance councils including, Central Partnership Council, Professional Development Council, Nursing Research Council, Direct Care Informatics Council, Patient Care Leadership Council, Peer Review Committee, Night Shift Council (once initiated).

b. Magnet Program Director

c. Nurse Retention Specialist

d. Nursing Research Manager

2. ~~**Functions**~~

~~a. The purpose of the CNO Advisory Cabinet is to provide advice and counsel of the nursing division in order to promote alignment and achieve the nursing divisions' strategic goals and objectives~~

~~b. Participate in setting the annual nursing strategic plan~~

~~c. Gaining alignments on all shared governance councils annual goals and objectives~~

~~d. Actively participates in the planning and executing annual events such as nurses week.~~

~~e. Actively participates in the ongoing attainment of the Magnet standards.~~

Functions

a. Strategic Alignment and Goal Setting: The CNO Advisory Cabinet advises the nursing division to promote alignment with strategic goals, participates in setting the annual nursing strategic plan, and ensures alignment across shared governance councils.

b. Support for Organizational Excellence: Actively contributes to achieving Magnet standards and aligns goals with the hospital's mission, vision, values, strategic plan, and industry benchmarks.

c. Event Planning and Engagement: Participates in planning and executing

COPY

initiatives like Nurses' Week to enhance engagement and celebrate professional practice.

d. Continuous Improvement and Innovation: Focuses on improving staffing, cost-saving strategies, recruitment, retention, and adapting services to meet growing patient care demands.

3. **Meeting Frequency/Minutes Processes**Meeting Frequency/Minutes Processes
    a. Meetings are scheduled for 1 hour monthly.
    b. Meeting minutes are recorded by the CNO or designee and disseminated via email to council members.
    c. Decision making is by consensus of a quorum of members present, either by phone, Zoom, or proxy vote.

P. **GOALS**

1. Goals are established and/or reviewed at least annually. The CNO and the nursing leadership establish the goals of Patient Care Services.
2. Goals are based on several factors, including:
    - Hospital's mission, vision, values and strategic plan.
    - Findings from the performance improvement and human resource systems.
    - Information on new trends in patient care, nursing, and management.
    - Patient satisfaction, employee satisfaction, and physician satisfaction measurement.
    - Standards of practice in the community and / or established database benchmark..
    - El Camino Hospital Strategic Plan priorities.
      Short and longer-term goals for Patient Care Services include the following:
    - Implementation of improved staffing controls and cost saving ideas in order to bring the nursing division to break even each fiscal year end while enhancing the professional practice of nursing.
    - Improvement in the recruitment and retention of registered nurses and other patient care staff.
    - Review and modification of management structure to support strategic direction.
    - Implementation of strategies to accommodate the growing demand for inpatient maternity and neonate services.

Q. **NURSING PARTICIPATION IN THE HOSPITAL'S DECISION MAKING STRUCTURES AND PROCESS**NURSING PARTICIPATION IN THE HOSPITAL'S DECISION MAKING STRUCTURES AND PROCESS

1. The Chief Nursing Officer, Nursing Directors, Clinical Managers and Assistant

Hospital Manager/Hospital Supervisors participate with members of the Governing Board, Medical Staff and Administration in the Hospital's decision making structures and process.

2. The Nurse Executive of El Camino Hospital is titled the Chief Nursing Officer, and has been in management for over five years. He/she/they is a registered nurse, with a Master's degree in nursing or a related field. He/she/they serves on a full-time basis and is responsible and accountable for all activities within nursing services. He/she/they reports to the Chief Operations Officer with a matrix reporting relationship to the CEO.
3. The Nurse Executive is involved in the organization's corporate decisions that affect nursing care and attends the Board of Directors meetings and other pertinent meetings regarding budget, goals, new services, and institutional planning.
4. The Nurse Executive and nursing directors/managers interact with the medical staff by attendance at medical staff meetings, executive committee meetings, and meetings of the Governing Board of the hospital. The Nurse Executive regularly attends the Medical Staff Executive Committee, the Quality Council, the Utilization Management Committee. The Nurse Executive or his/her designee reports on the activities of the Nursing Division to appropriate medical staff committees as well as to the Executive Committee and to the Governing Board.

R. ~~**NURSING'S MEMBERSHIP ON HOSPITAL AND MEDICAL STAFF COMMITTEES**~~
NURSING'S MEMBERSHIP ON HOSPITAL AND MEDICAL STAFF COMMITTEES
To facilitate communication between nursing, other hospital departments and the medical staff, and to ensure nursing's involvement in the achievement of the mission and goals of ECH, nursing is represented on specific hospital and medical staff committees.

COPY

~~**Hospital Committees-Enterprise**~~	~~**Medical Staff Committees-Enterprise**~~
~~CPR~~	~~Department of Medicine~~
~~IPIT (Interprofessional InfoTechnology)~~	~~Department of Maternal Child Health~~
~~Medication Safety~~	~~Department of Surgery~~
~~Performance Improvement Teams~~	~~Infection Control Committee~~
~~Patient and Employee Safety Committee~~	~~Operating Room Committee~~
~~Central Safety Committee~~	~~Pulmonary~~
~~Security Workgroup~~	~~Quality Council~~
~~Service Excellence Team Meeting~~	~~Special Services~~
~~Sharps/Safety Workgroup~~	~~Utilization Review~~
~~Value Analysis~~	
~~Cardiovascular Services~~	

Plan for Provision of Nursing Care (cont)

~~Patient Safety Oversight Committee~~	
~~RCA Steering Committee~~	
~~Institutional Review Board~~	
~~Interdisciplinary Practice~~	
~~Medical Ethics~~	
~~Patient Experience Teams~~	
~~Pharmacy and Therapeutics~~	

• Hospital Committees-Enterprise	• Medical Staff Committees-Enterprise
CardioPulmonary Resuscitation (CPR)	Department of Medicine
Acute Care Decision Making IT Committee	Department of Maternal Child Health
Medication Safety	Department of Surgery
Performance Improvement Teams	Infection Control Committee
Patient and Employee Safety Committee	Operating Room Committee
Central Safety Committee	Pulmonary
Security Workgroup	Quality Council
Patient Experience Team	Special Services
Sharps/Safety Workgroup	Utilization Review
Value Analysis	
Cardiovascular Services	
Patient Safety Oversight Committee	
RCA Steering Committee	
Institutional Review Board	
Interdisciplinary Practice	
Medical Ethics	
Pharmacy and Therapeutics	
RN Retention Steering Committee	
Inclusion, Diversity, Equity, and Belonging (I-DEB) Committee	

COPY

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

Approval Signatures

Step Description	Approver	Date
ePolicy Committee	Patrick Santos: Policy and Procedure Coordinator	Pending
	Cheryl Reinking: Chief Nursing Officer	11/2024

COPY

Status **Pending** PolicyStat ID **17132601**

Origination	09/1994	Owner	Gwen Chambers: Interim Director Human Resources
Last Approved	N/A	Area	Human Resources
Effective	Upon Approval	Document Types	Policy
Last Revised	12/2024		
Next Review	3 years after approval		

Equal Employment Opportunity/ Disability and Reasonable Accommodation

COPY

COVERAGE:

This policy applies to all El Camino Hospital employees. If there is a conflict between the Hospital's policy and the applicable Memorandum of Understanding (MOU), the applicable MOU will prevail.

PURPOSE:

~~El Camino Hospital is an equal opportunity employer and makes employment decisions on the basis of qualifications and competencies. El Camino Hospital strictly prohibits unlawful discrimination or in employment based on race, ancestry, national origin, color, sex, sexual orientation, gender identity, religion, disability, marital status, age, medical condition (rehabilitated cancer and genetic characteristics), inappropriate refusal of protected leaves, in retaliation for engaging in any activity protected by law, status as a victim of domestic violence, sexual assault or stalking, enrollment in a public assistance program, or based on any other status protected by federal, state or local law, ordinance or regulation. El Camino Hospital also prohibits discrimination or harassment based on the perception that anyone has any of those characteristics, or is associated with a person who has or is perceived as having any of those characteristics. All such discrimination is unlawful and will not be tolerated.~~

El Camino Hospital is committed to providing equal employment opportunities to all employees and applicants for employment. Employment decisions are based solely on qualifications and competencies. The Hospital strictly prohibits unlawful discrimination in employment. This includes discrimination based on race, color, religion, religious creed (including religious dress and grooming practices), national

origin, ancestry, citizenship, physical or mental disability, medical condition (including cancer and genetic conditions), genetic information, marital status, sex (including pregnancy, childbirth, breastfeeding, or related medical conditions), gender, gender identity, gender expression, reproductive health decision making, age (40 years and over), sexual orientation, veteran or military status, domestic violence victim status, political affiliation, and any other characteristic protected by state or federal antidiscrimination law covering employment.

Discrimination or harassment based on perceived characteristics, or associations with individuals who have or are perceived as having any of these protected characteristics, is also prohibited. This commitment applies to ~~all persons~~all individuals involved in the operations of ~~El Camino Hospital~~the hospital, including supervisors~~ and co-workers~~, ~~and applies~~coworkers, vendors, and contractors. It extends to all employment practices, including ~~advertisements;~~advertising, recruitment, applications~~ and~~, interviews~~;~~, licensing or certification~~;~~, referrals by employment agencies~~; salary~~, compensation, job classifications and duties~~;~~, hiring, ~~transferring~~transfers, ~~promoting or leaving a job;~~promotions, separations, working conditions~~;~~, participation in ~~a~~ training or apprenticeship ~~program~~programs, and involvement in employee ~~organization, or union~~organizations or unions.

STATEMENT:

~~This policy is written to ensure understanding of and compliance with California and Federal laws which prohibits discrimination in employment.~~

This policy ensures compliance with the California Fair Employment and Housing Act (FEHA), Section 504, Rehabilitation Act of 1973, Title VII of the Civil Rights Act, the Americans with Disabilities Act (ADA), and other applicable laws that prohibit discrimination in employment.

COPY

DEFINITIONS:

1. ~~It is the responsibility of every employee, regardless of supervisory status, to adhere to these policies. An employee who is found to have violated the Discrimination and Harassment policy shall be subject to disciplinary action up to and including termination.~~
2. ~~To assure the dignity and worth of each individual, El Camino Hospital managers and supervisors are responsible to provide an environment which is committed to this policy.~~

- Every employee, regardless of supervisory status, is responsible for adhering to this policy. Any employee found to have violated the Equal Employment Opportunity or Disability and Reasonable Accommodation Policy will face disciplinary action, up to and including termination.
- El Camino Hospital managers and supervisors are responsible for fostering an environment that upholds this commitment to equal opportunity and inclusion.

PROCEDURE:

~~Individuals with a Disability - Reasonable Accommodation~~

~~(*See* California Government Code § 12926 and the federal Americans with Disabilities Act 42 U.S.C. 12101, *et seq*.)~~

1. ~~The manager will make good faith attempts to provide reasonable accommodation for the known physical or mental limitations of an individual with a disability who is an applicant or employee, unless an undue hardship would result.~~
2. ~~Any applicant or employee who requires an accommodation in order to perform the essential functions of the job will contact Human Resources and/or the appropriate manager and specify the restrictions on job duties and what accommodation is being requested to perform the essential functions of the job. Human Resources and the appropriate manager, will conduct an interactive process to identify any barrier(s) that would make it difficult for the applicant or employee to perform her/his essential job functions, and potential accommodations which would allow the essential functions of the job to be performed. Employee Wellness & Health Services may be consulted if needed. If the accommodation is deemed reasonable and will not impose an undue hardship, the manager in consultation with Human Resources will make the accommodation.~~
3. ~~If an applicant or employee believes she/he has been subject to any form of unlawful discrimination, she/he should provide a written complaint to Human Resources or the manager.~~

COPY

~~Procedure for Discrimination Complaints~~

1. ~~An individual who believes that she/he has not received equal opportunity in employment should report the incident to her/his direct supervisor, manager, department director or to a Human Resources Business Partner or the Director of Human Resources Operations immediately. The report should be submitted in writing. If the incident involves the employee's direct supervisor, manager or department director, the employee must report the incident immediately to the Human Resources Department. Employees are to be assured that their doing so will not result in any reprisal or retaliation.~~
2. ~~The written complaint must be specific and include the dates of the alleged incident, names of the individuals involved, names of any witnesses, and as much information as possible regarding the complaint. El Camino Hospital will timely initiate an effective, thorough and objective investigation and attempt to resolve the situation.~~
3. ~~Any department director/manager/supervisor who receives a report or complaint of a violation of this policy must report it immediately to a Human Resources Business Partner or the Director of Human Resources Operations.~~
4. ~~If El Camino Hospital determines that unlawful discrimination has occurred, effective remedial action will be taken, commensurate with the severity of the offense. Appropriate action will also be taken to deter any future discrimination.~~

5. ~~El Camino Hospital will not retaliate against any employee for filing a complaint and will not knowingly permit retaliation by management or coworkers.~~

Individuals with a Disability - Reasonable Accommodation

Under the California Fair Employment and Housing Act (Government Code Section 12926) and the federal ADA (42 U.S.C. § 12101 et seq.), El Camino Hospital is committed to making reasonable accommodations for the known physical or mental limitations of applicants or employees with disabilities, unless doing so would impose an undue hardship on the hospital's operations.

A. Applicants or employees who require accommodations to perform essential job functions must contact Human Resources and/or their manager. They should specify any job restrictions and requested accommodations.

B. Human Resources and the appropriate manager will engage in an interactive process to identify barriers preventing job performance and explore potential accommodations. Employee Wellness & Health Services may be consulted as needed.

C. If a reasonable accommodation is identified that does not impose undue hardship, it will be implemented in consultation with the manager and Human Resources.

D. Any applicant or employee who believes they have been subject to unlawful discrimination may file a written complaint with Human Resources or their manager.

Procedure for Discrimination Complaints

A. An individual who believes that she/he has not received equal opportunity in employment should report the incident to their direct supervisor, manager, department director or to a Human Resources Business Partner or the Labor Relations Manager immediately. If the incident involves the employee's direct supervisor, manager or department director, the employee must report the incident immediately to the Human Resources Department.

B. Complaints must be submitted in writing and should include specific details such as the dates of the incident, names of those involved, names of witnesses, and other relevant information.

C. Upon receiving a complaint, El Camino Hospital will promptly initiate an effective, thorough, and objective investigation to resolve the situation.

D. Department directors, managers, and supervisors who receive a report of discrimination must immediately notify Human Resources.

   If unlawful discrimination is found to have occurred, El Camino Hospital will take appropriate remedial action commensurate with the severity of the offense. Preventive measures will also be implemented to deter future incidents.

Retaliation

El Camino Hospital strictly prohibits retaliation against employees for filing a complaint or participating in an investigation. Any employee who engages in retaliation will face disciplinary action, up to and including termination.

This policy is a commitment to maintaining a respectful, inclusive, and legally compliant work environment for all employees and stakeholders.

COPY

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

Attachments

Image 1

Approval Signatures

Step Description	Approver	Date
HR Leaders including CHRO	Simone van der Molen: Manager HR Business Partners	Pending
HR Leaders including CHRO	Gwen Chambers: Interim Director Human Resources	Pending

COPY