Washington Township Health Care District
2000 Mowry Avenue, Fremont, California 94538-1716 | 510.797.1111
Kimberly Hartz, Chief Executive Officer

BOARD OF DIRECTORS MEETING
Wednesday, March 27, 2024 – 6:00 P.M.
Board Room of Washington Hospital, 2000 Mowry Avenue, Fremont and via Zoom
https://zoom.us/j/97551058359?pwd=QnRmNlIzdzBmbXBJVU51bm02Ujd6dz09
Passcode: 725156

Board Agenda and Packet can be found at:
March 2024 | Washington Hospital Healthcare System (whhs.com)

AGENDA

		PRESENTED BY:
I.	**CALL TO ORDER & PLEDGE OF ALLEGIANCE**	Jacob Eapen, MD President
II.	**ROLL CALL**	Cheryl Renaud District Clerk
III.	**COMMUNICATIONS**	
	A. Oral *This opportunity is provided for persons in the audience to make a brief statement, not to exceed three (3) minutes on issues or concerns not on the agenda and within the subject matter of jurisdiction of the Board. "Request to Speak" cards should be filled out in advance and presented to the District Clerk. For the record, please state your name.*	
	B. Written	
IV.	**CONSENT CALENDAR** *Items listed under the Consent Calendar include reviewed reports and recommendations and are acted upon by one motion of the Board. Any Board Member or member of the public may remove an item for discussion before a motion is made.*	Jacob Eapen, MD President
	A. Consideration of Proposal to Establish Emergency Medicine Department and Departmental Manual	*Motion Required*

V.	**ACTION**	
VI.	**ANNOUNCEMENTS**	
VII.	**ADJOURN TO CLOSED SESSION**	Jacob Eapen, MD President
	A. Consideration of Closed Session Minutes of the Meetings of the District Board: February 14 & 28, 2024	*Motion Required*
	B. Reports regarding Medical Audit & Quality Assurance Matters pursuant to Health & Safety Code Section 32155 • Medical Staff Committee Report	*Motion Required*
	C. Conference involving Trade Secrets pursuant to Health & Safety Code Section 32106 • Strategic Planning	
	D. Conference with Labor Negotiators pursuant to Government Code Section 54957.6 Agency designated representative: Kimberly Hartz, Chief Executive Officer	
	E. Conference involving Personnel Matters: Chief Executive Officer	
VIII.	**RECONVENE TO OPEN SESSION & REPORT ON PERMISSIBLE ACTIONS TAKEN DURING CLOSED SESSION**	Jacob Eapen, MD President
IX.	**ADJOURNMENT**	Jacob Eapen, MD President

In compliance with the Americans with Disabilities Act, if you need assistance to participate in this meeting, please contact the District Clerk at (510) 818-6500. Notification two working days prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to this meeting.

Washington Hospital Healthcare System

S I N C E 1 9 4 8

Memorandum

DATE: March 18, 2024

TO: Kimberly Hartz, Chief Executive Officer

FROM: Mark Saleh, MD, Chief of Staff

SUBJECT: MEC for Board Approval

The Medical Executive Committee, at its meeting on March 18, 2024, approved the attached "Proposal to Establish Emergency Medicine Department and Departmental Manual".

Please accept this memorandum as a formal request for presentation to the Board of Directors for final approval of the attached "Proposal to Establish Emergency Medicine Department and Departmental Manual".

DEPARTMENT & SERVICES MANUAL

DEPARTMENT OF EMERGENCY MEDICINE

DEPARTMENT OF EMERGENCY MEDICINE

Definitions

Department of Emergency Medicine - a division of the Medical Staff for the provision of a specified type of diagnosis or treatment.

Emergency Department - the physical space in which care is provided.

Emergency Services - the place, the care provided and those providing the care.

Function

The function of the Department of Emergency Medicine shall be to provide 24-hour professional coverage of medical and surgical emergencies. This coverage shall be the joint responsibility of the Medical Staff, in coordination with the Hospital Administration.

The Emergency Department is a Level II Facility. The Emergency Department's goal is to provide timely, courteous, appropriate, compassionate, convenient, cost effective emergency medical interventions.

Subject to approval of the MEC, the Department shall perform the functions assigned to it by the Department Chairperson. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices, credentials review and privilege delineation and continuing education programs. The Department shall transmit regular reports to the Chief of Staff and MEC on its assigned functions. Any recommendation involving peer review and quality assurance activities is subject to Department of Emergency Medicine approval. Members of the Department of Emergency Medicine shall comply with the Bylaws, Policies and Procedures, and Rules and Regulations of the Washington Hospital Medical Staff and the Department of Emergency Medicine manual.

The Department of Emergency Medicine shall assure the following:

1. A Board eligible/certified physician in emergency medicine is assigned to the Emergency Department and on the premises 24 hours a day. The Emergency physician roster shall be prepared by the Emergency Medical Director in coordination with the Administrator responsible for the oversight of the Emergency Department.

2. A roster of physicians on call for referral is available in the Emergency Department.

3. Electronic medical records are maintained on all patients who present for treatment. Records of the Emergency Department are regularly reviewed by the existing Medical Staff review committees.

4. No patient can be denied treatment or have treatment delayed due to race, creed, color, religion, sex or financial status.

5. Patients presenting to the Emergency Department for care will receive a medical screening examination (MSE) regardless of their ability to pay or insurance coverage in accordance with State/Federal Regulations.

THE OBJECTIVES OF THE EMERGENCY SERVICE

1. To provide evaluation and initial treatment in an organized and directed manner consistent with the defined capability of the hospital.

2. To integrate fully with other departments of the hospital and with the surrounding community, including disaster planning.

3. To ensure that medical care meets general standards of other departments in the Hospital and surrounding hospitals in the community 24 hours a day.

4. To ensure adequate staffing 24 hours a day to meet the needs of emergency patients.

5. To ensure that patients are seen within a reasonable length of time relative to their illness or injuries.

6. To provide, with the Hospital Medical Staff, a means of auditing the quality of emergency care provided.

7. To ensure that all staff members, physicians and hospital staff, working within the Emergency Department receive adequate special training and possess the necessary skills for adequate performance of their duties.

8. To ensure that the facilities for emergency services are such that effective care to the patient can be provided.

9. To guide emergency patient care with written policies that are supported by appropriate procedure manuals and reference materials.

10. To ensure that adequate medical records are maintained for every patient receiving emergency service.

11. The direction of the Emergency Department is carried out by a member of the Medical Staff who acts as full time Director.

12. Supervision of quality is carried out jointly by the Medical Director of the Emergency Department (hospital component) and by the Department of Emergency Medicine (professional component).

13. The immediate medical care delivered within the Emergency Department is the responsibility of the emergency physicians on duty.

14. If a patient has been admitted to the hospital but is kept in the Emergency Department because a bed is not available in the inpatient units or in ICU-CCU, the admitting physician is responsible for the complete care of that patient, unless emergent intervention is required.

Composition

The Department of Emergency Medicine will be composed of those members who have satisfactorily completed the formal training requirements of the American Board of Emergency Medicine/American Osteopathic Board of Emergency Medicine and who have met the requirements of staff membership. They shall provide 24-hour professional coverage in accordance with the Policies of this Department under the supervision of its Chair.

Officers

A Department Chairperson and an Assistant Chairperson shall be ~~s~~elected from the Active Medical Staff members of the Department for a two-year term. The Chairperson and Assistant shall be qualified by training and experience and demonstrate current ability in emergency medicine.

Elections shall be held in May of odd years. Chairpersons shall be eligible to succeed themselves.

If a vacancy should arise in the department chair position, the assistant chair will assume the role and a special election will be held to fill the role of assistant chair. The department may adopt department-specific rules on vacancies by majority vote. The assistant chair will complete the current term and his/her scheduled term.

The Chairperson shall preside at the Department Meetings and shall perform the duties outlined in the Medical staff Bylaws.

The Assistant Chairperson shall preside and conduct business in the absence of the Chairperson.

Organization

1. The Department of Emergency Medicine will send the Chairperson to the Medical Executive Committee and the Assistant Chairperson to the Quality and Resource Management Committee. The Department Chair may elect to send a representative In consultation with the Chief of Staff/ Chair of the particular Department to a particular Section or Department Committee meeting.

2. The Department meeting shall be open to all active members of the Department of Emergency Medicine. Pertinent representatives from outside Departments will be appointed to the Departments Committee in odd years by the Chief of Staff in consultation with the Chair of the Department of Emergency Medicine; they will not have voting rights in the committee meeting.

3. All policy decisions of the Department shall be subject to approval, modification or rejection by a simple majority of the active voting members of the Department.

4. Develop and implement programs to carry out the quality review, monitoring and evaluation functions assigned to the Department of Emergency Medicine.

5. Assist in the evaluation of the clinical work performed in the Department.

6. Perform other appropriate duties as requested by the Chief of Staff or the Medical Executive Committee.

Meetings

The Department of Emergency Medicine and it's Committee shall meet every other month (except the November meeting will occur the first week in December) and shall generate minutes of the business conducted. The agenda for these meetings shall include Departmental matters, generate policy for the Department and the conduct of both Professional Practice Evaluation (PPE – formerly, peer review) and Quality Assessment and improvement. Minutes shall include a summary of PPE findings for information and educational purposes. QA data with executive summary attached will be submitted to the Quality and Resource Management Committee at regular intervals determined by the QRM committee.

Privileges

A. Evaluation and re-evaluation of applicants:

The Department of Emergency Medicine shall evaluate all applicants for Emergency Medicine privileges. The Committee's recommendation will be forwarded to the Medical Executive Committee via the Credentials Committee. Re-evaluation of privileges shall occur every two (2) years.

B. Core Privileges (Privilege documents can be found in the software program library of the Medical Staff Office):

The Department of Emergency Medicine shall define Core Privileges appropriate to the specialty and submit for approval.

C. Eligibility:

To be eligible for Core Privileges, a practitioner must be Board certified as outlined in the Medical Staff Bylaws. The practitioner must have performed a minimum of 200 cases of a variety of the procedures within the Core in the previous two years.

Responsibilities of Emergency Medicine Physicians

Emergency physicians are members of the Medical Staff with privileges granted by the Board of Directors.

1. The Emergency physician's prime responsibility is the prompt evaluation, treatment and disposition of all patients requiring and requesting treatment.

2. Emergency physicians shall also respond promptly to pediatric "code pink" within the hospital until the patient's attending physician or another qualified physician is available, providing that such temporary removal from the emergency area does not disrupt an equally life-saving procedure being performed in that area.

3. Updated ACLS certification is recommended but not a requirement for renewal of the privileges of an emergency physician.

4. Protection of patient-physician relationships within the community, and cooperative effort of staff and emergency physicians shall be encouraged by clearly defining responsibilities and by mutual understanding of the problems of patient care inherent to each mode of practice.

5. While on duty, emergency physicians shall not accept "sign-out" coverage from members of the Medical Staff outside of other members of the Department of Emergency Medicine

6. To assist the staff nurse in deciding the order of urgency of different patients' problems and to treat patients in that order.

7. To interview, examine and establish a tentative diagnosis on all patients he/she attends**,** to stabilize and initiate appropriate care, to refer for admission or to render outpatient treatment (as appropriate).

8. To treat patients with respect, kindness, compassion, diligence, skill and knowledge compatible with accepted medical standards.

9. To obtain consultations and other assistance whenever necessary.

10. To record all pertinent details of the evaluation and treatment of patients legibly and accurately.

11. To provide the patient with legible and understandable instructions concerning further care and follow-up.

12. To encourage patients to seek on-going care from a primary physician rather than relying on episodic care in the Emergency Department.

13. To determine the time of death in terminal cases and to certify those dead on arrival, to notify the Coroner and the patient's next of kin when necessary.

14. After admission of a patient from the Emergency Department, the emergency physician shall not assume responsibility for future treatment of that patient but may expedite initial inpatient care by writing orders upon authorization by the patient's physician. Once a patient leaves the Emergency Department, the admitting physician takes full responsibility for the patient, including reviewing the admit-holding orders and or any future orders or treatment.

15. Referral and consultation shall be coordinated with members of the Medical Staff as outlined in this manual. Return or follow-up visits to the Emergency Department for the same illness should be discouraged.

16. The Emergency physicians must be capable of evaluating patients involved in alleged rape, sexual assault, and child molestation.

17. It shall be the responsibility of the emergency physician to seek assistance from on-call physicians as well as from Emergency Department Nurse Manager when needed to assure that patients with high priority problems shall be seen immediately, so that those with less severe problems shall not be subjected to unnecessary delays, and so the patient load in the Emergency Room shall not get so heavy that patients cannot be monitored and otherwise evaluated and treated in an organized manner that will prevent or minimize oversights and errors.

Specialty Coverage for Emergency Department

An on call roster is maintained by the hospital to ensure the availability of physicians and specialists to provide treatment in accordance with Medical Staff Department and Section Manuals.

PATIENT CARE GUIDELINES

Procedures That May Not Be Performed by the Medical Staff in the Emergency Department

1. No provision of care without proper completion of forms and informed consent.

2. No minor elective surgery other than those specified in this manual.

3. No routine allergy hyposensitization.

4. No procedures or treatment of an experimental nature.

5. No prolonged care of violent or suicidal patients; they will be transferred to an appropriate facility elsewhere as soon as practicable.

6. No holding of patients, in excess of 12 hours, for care of problems without administrative advice.

7. General inhalation anesthesia is not to be administered in the Emergency Department under normal situations.

8. Any delivery that can be done in a delivery room.

9. Any D&C that is greater than 13 weeks size.

10. Laparotomy.

11. Craniotomy, excluding emergency burr holes.
12. Lymph node biopsy/excision.
13. Diagnostic bronchoscopy.
14. Elective cardioversion.
15. Elective placement of pacemaker.
16. Circumcision
17. Removal of cysts, wens, and chalazions
18. Elective D&C
19. Therapeutic abortions
20. Elective therapeutic and diagnostic nerve blocks
21. Plastic surgical revision of scars
22. Scheduled tracheotomy
23. A-V shunts for dialysis patients.

Patient Refusal of Exam or Treatment

In the event that a patient refuses to consent to further examination or treatment, the physician must indicate in writing the risk and benefits of the examination and/or treatment, the reason for the refusal, a description of the examination or treatment that was refused, and steps taken to secure written informed refusal.

Emergency Department Discharge/Admissions/Transfers

Emergency Department transfers are done in accordance with hospital policies and federal and state requirements.

1. Responsibility for Discharge and Disposition

   Patient discharge and disposition shall be decided by the physician.

2. Prerequisites for Discharge

   Discharged patients shall be instructed regarding:

   a) What additional care is recommended.

   b) How to obtain and how to use any medicines that may have been prescribed or otherwise recommended.

   c) What follow-up arrangements are recommended and how to make these arrangements.

   d) When and how to return or call to the Emergency Department or to otherwise obtain earlier care or advice should they unexpectedly worsen or should anticipated recovery not take place.

Guidelines for Pain Management

(Approved by Board 2/13/02)

Patients have the right to appropriate assessment and management of pain. The Washington Hospital Healthcare System will maintain pain management practices that promote an optimal level of comfort, eliminate avoidable pain, and take into account personal, cultural, spiritual, and/or ethnic beliefs.

Effective pain management is appropriate for all patients. Unrelieved pain has adverse physical and psychological effects. Pain will be assessed and treated promptly, effectively, and for as long as pain persists. Staff education regarding diagnosis, assessment and treatment of pain will be ongoing and part of the pain management process.

I. Initial Assessment of Pain
   - A. In the initial assessment, patients will be screened for the presence (or absence) of pain.
   - B. A more comprehensive assessment will be performed when warranted by the patient's condition and will include a measure of pain intensity and quality appropriate to the patient's age.

II. Use of the Pain Scale
   - A. The patient's self-report of pain shall be considered the single most valuable indicator of pain.
   - B. The appropriate scale will be used to assess pain in pediatric and other non-verbal and or unconscious patients who are unable to utilize the 0-10 numeric or faces scale.

III. Ongoing Assessment of Pain/Interventions
   - A. Pain intensity will be assessed at regular intervals, with vital signs, or more frequently, as needed.
   - B. The results of pain assessment/reassessment will be appropriately documented.

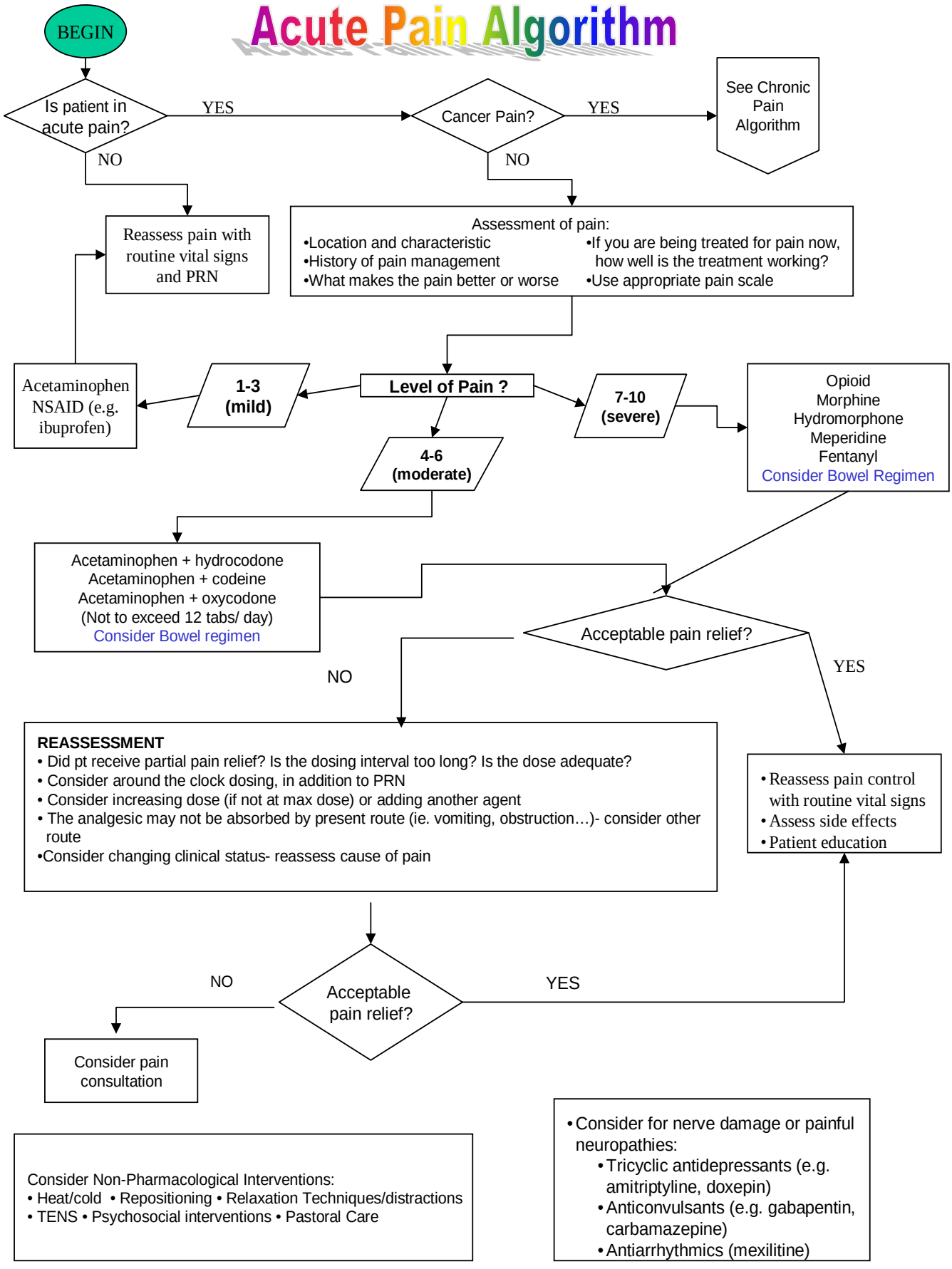
IV. Patient and Family Education
   - A. Patients will be educated about pain and managing pain.
   - B. When appropriate, patients and families are instructed about understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process (including the pain scale), and methods for pain management, when identified as part of treatment.

V. Pain Management at Discharge
   - A. A pain level will be assessed during the discharge process and will be documented.
   - B. Patients will be provided with appropriate instructions for follow-up should pain continue to be an issue.

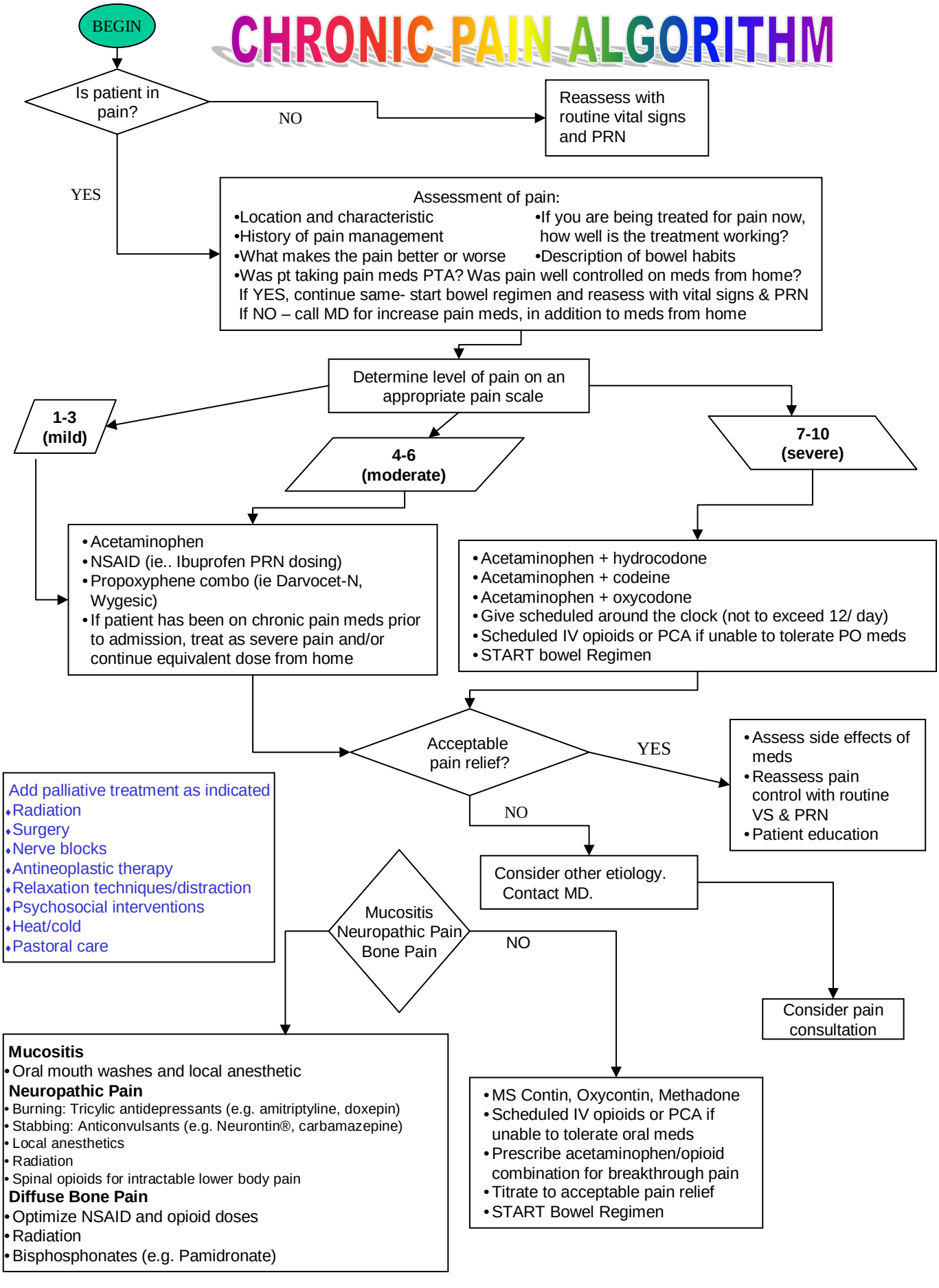
VI. Organization Monitoring and Evaluation

There will be continual, ongoing monitoring of the effectiveness of pain management practices through quality improvement processes.

Acute Pain Algorithm



CHRONIC PAIN ALGORITHM



Alcohol Impaired Patients

The Emergency physician must specifically address the patient's improving/sobering/mental status, stable vital signs, ability to safely ambulate and to be prudently discharged to family/friends or where applicable the authorities. Where clinically indicated, the physician should consider a repeat blood alcohol prior to discharge if a baseline blood alcohol was done and was over 0.8%.

Privilege Application Form – Department of Emergency Medicine (see MSO software library)

Amendment

Recommended changes to the Department of Emergency Medicine Manual shall require an affirmative vote of 51% of the voting members of the Department, followed by approval of the MEC and the Board of Directors.

APPROVED BY DEPARTMENT OF EMERGENCY MEDICINE
Date:

APPROVED BY THE MEC
Date:

APPROVED BY THE BOARD OF DIRECTORS
Date:

Emergency Department Fast Track Guidelines

Goal: To see 20% of shift census in Fast Track and 80% of Fast Track patients in one hour from triage to discharge. To decrease patients who leave without being seen to less than 2%.

Hours

Fast Track will be implemented daily from 1200 to 2300p with final disposition and discharge of patients prior to 2300.

Staffing

The LVN on duty will staff Fast Track. In the absence of an LVN the float RN may staff it. When staffed by a non-licensed person nursing functions will be implemented by the charge or float nurse.

Location

Fast track patients will be seen and treated in the Cast room or clinic. Fast track patients waiting for results of diagnostic studies will wait in the ED cubby area.

Fast Track Patient Criteria

General Criteria:

Exclusion Criteria:

- patients that can be seen and treated within one hour (i.e. simple rechecks, suture removal, simple lacerations, back pain without fever or neuro symptoms, sore throat, URI, blood and body fluid exposure, conjunctivitis, dysuria without abdominal pain, etc) Generally all Triage level 4 and 5's.
- Minimal preferably no blood work
- labs preferably limited to UA, accucheck or strep screen
- x-rays limited to chest or single extremity
- no IVs or IV medications unless there's limited availability of main ED bed.
- Limited consultations

- Psychiatric complaints
- Patients with potential for admission
- Abdominal pain
- Nausea/vomiting
- Children under 4 months old

Procedure

Triage:	The triage nurse will determine which patients meet Fast Track criteria; will enter FT in the upper right hand corner of the ED clinical record at time of registration; and place a green Fast Track dot on the top of the clinical record.
Patient prep:	Patient is roomed by assigned staff and the patient is prepared for anticipated treatment. Patient chart will be flagged on EPIC to alert ED physician of the waiting fast track patient.
ED MD:	ED Physician evaluates patient and orders any necessary diagnostic studies.
Patient care:	Patient can be placed in ED cubby to wait for results if other fast track patients waiting. Patients are brought back to treatment area for definitive care and patient teaching.
Discharge	Patients are discharged by the emergency physician or assigned staff. (remember ED techs may not discharge patients but LVN's may)

Documentation: ED clinical record:

- Check the box in the secondary survey that refers to the ED Physician notes for assessment.
- The LVN or tech may document focused musculoskeletal findings, pain scale, and screening questions.
- Continue to document all care, teaching, and discharge areas.
- Follow policy for revitals and completion of chart.

Shift report:

- Indicate number of fast track patients treated during the shift.

❑ **Chest Pain-Presumed cardiac in nature**	❑ **Dyspnea / CHF / Pneumonia**	❑ **Extremity Injury**
· STAT EKG and show to ED MD · IV saline lock · Draw blood · O2 @ 2L via N/C, Cardiac monitor, pulse oximeter · ASA 324 mg PO chewed (if no allergy to ASA and not taken prior to arrival) · NTG 0.4mg sublingual every 5 min x 3 for chest pain if SBP>90mm Hg · Notify physician of persistent pain.	· Draw blood including Blood cultures x 2 if pneumonia suspected · O2 as appropriate ○ 2L via N/C for COPD pts ○ Maintain pulse ox >92% for non- COPD pts · IV saline lock · Chest x-ray · Anticipate administration of antibiotics for pneumonia patients within 6 hours of arrival to ED.	· Determine mechanism of injury and exact location of pain. Evaluate joint above and joint below the injury for tenderness. Order appropriate x-ray ❑ Right / Left (circle) ❑ Right /Left (circle) · Immobilize / Elevate injured extremity · Apply cold compress if injury is less than 48 hours old · Saline lock for obviously displaced fractures / severe pain · Treat pain as indicated below.
❑ ***Asthma***	❑ ***Pain***	❑ **Lacerations/Wounds**
· O2 as appropriate: Maintain pulse ox >92% for non-COPD pts · IV saline lock · Continuous pulse oximetry · Stat Albuterol 2.5mg neb with peak flow before and after · Anticipate administration of IV steroids · Notify ED MD of patient's presence and presentation	Mild to moderate soft tissue and/or musculoskeletal pain; no allergy; no history of GI bleed or asthma: **Adults** · Ibuprofen 400 mg PO **Pediatrics** · Ibuprofen 10mg/kg PO Severe pain, other cause, or need to be NPO consult EDMD	· Cleanse wound with normal saline · Document tetanus immunization status o If longer than 10 years administer 0.5ml Tdap IM · Suture set-up at bedside · Anticipate post-suture clean up and dressing administration
❑ Pediatric Fever	**Protocol related to eye emergencies has been deleted**	**Signatures**
· Determine last dose of antipyretics		

· Acetaminophen 15 mg/kg PO or fever > 100.4 rectal and if > 4hours from last dose . May give rectally if vomiting. · Ibuprofen 10mg/kg PO if continued fever >1hour post administration of acetaminophen and more than 6 hours since last does of ibuprofen.		ARN Signature Print name and title Date: Time:

***Check the appropriate box to activate the order set within the chosen box. May check pain box in addition to laceration/wound or extremity injury

Emergency Department
Nurse Initiated Protocols
(Patient Care Services Division
Structure Standards/Generic
https://mywhhs/PCS/Docs/Nurse%20initiated%20ED%20Care.pdf)

- Abdominal Pain
- ALOC – suspected stroke
- Asthma
- Chest pain presumed cardiac
- Extremity injury
- Fever management
- MRSA Screening by PCR
- Musculoskeletal Pain
- Suspected pneumonia
- Suspected Sepsis
- Urinary Tract Infection Screening
- Vaginal Bleeding