

GALLAGHER

GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

May 19, 2023

VIA EMAIL & FEDERAL EXPRESS MAIL

Ms. Eileen Fleck
eileen.fleck@maryland.gov
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Shore Health System, Inc.
Certificate of Conformance Responses to Additional
Information Question dated April 28, 2023

Dear Ms. Fleck:

On behalf of the applicant Shore Health System, Inc., we are submitting an electronic version and four (4) hard copies of its Certificate of Conformance Responses to Additional Information Questions dated April 28, 2023 for the Replacement and Relocation of University of Maryland Shore Medical Center at Easton. We will be providing a WORD version of the responses under separate email.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

If you have questions about the information provided above, please contact us at your convenience.

Very truly yours,



Thomas C. Dame



Mallory Regenbogen



Alison Lutich

cc: Ruby Potter, Health Facilities Coordination Officer, MHCC
Ben Steffen, Executive Director, MHCC
Wynee Hawk, RN, JD, Director, Center for Health Care Planning &
Development, MHCC
Alexa Bertinelli, Esq., Assistant Attorney General, MHCC

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Ms. Eileen Fleck
May 19, 2023
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**UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON.
CERTIFICATE OF CONFORMANCE FOR PRIMARY AND ELECTIVE
PERCUTANEOUS CORONARY INTERVENTION SERVICES
Matter No. 23-20-2463**

Responses to Additional Information Questions Dated April 28, 2023

1. **For the hospital's response to Question 23, one of the policies provided, Policy PCI-10, 3.1 states that the normal staffed hours of operation at the cardiac catheterization laboratory are Monday through Friday from 7:00 AM to 3:30 PM, which is not consistent with the schedule provided in response to Question 19 on the hospital's application. Please explain and provide updated information, as applicable.**

Applicant Response

The normal staff hours of operation at the cardiac catheterization are 7:00 a.m. to 5:30 p.m., as referenced in the response to Question 19 of the Certificate of Conformance Application. The Applicant has updated its Policy PCI-10 to correct the hours of operation. An updated copy of the policy is attached hereto as **Exhibit 18**.

2. **For the hospital's response to Questions 23, please provide the Telemetry Monitoring Protocol and the Cardiac Rhythm Monitoring Protocol referenced in the Admission to Telemetry Unit Policy. Additionally, please provide a list of orientation topics and annual competencies for staff in both the ICU and Telemetry units.**

Applicant Response

A copy of the Telemetry Monitoring Protocol is attached hereto as **Exhibit 19** and a copy of the Cardiac Rhythm Monitoring Protocol is attached hereto as **Exhibit 20**.

New staff members in the ICU and Telemetry units undergo a standard orientation process that includes several topics pertaining to PCI and STEMI care. All new ICU and Telemetry Unit staff review UM SMC at Easton's Primary Coronary Intervention (STEMI) Policy (PC-10) and Identification of Patients Having a STEMI Policy (PC-32), both of which are included in Exhibit 5 to UM SMC at Easton's Certificate of Conformance Application. Staff complete a self-learning module focused on Cardiac Catheterization and PCI that requires a post-test and evaluation of a skills checklist. This process is completed annually. A copy of the Annual ICU Skills Checklist, with relevant PCI training topics highlighted, is attached hereto as **Exhibit 21**. A copy of the Annual Telemetry Unit Skills Checklist, with relevant PCI training topics highlighted, is attached hereto as **Exhibit 22**. Staff members also complete an annual dysrhythmia competency. Additionally, novice staff members are required to attend a class on STEMI/PCI and a 12 lead EKG class. ICU staff members are required to participate in an annual hands-on training session on the same day they complete the annual skills tests.

Monitor techs working in the ICU and Telemetry Units receive basic dysrhythmia training that includes ST segment changes and complete the annual dysrhythmia competency.

3. In the revised Form B, provided April 13, 2023, why are the staffing costs for 2023 so much lower compared to the actual costs in 2022? Why do staffing costs remain significantly lower in the following years, as compared to the actual cost for 2022?

Applicant Response

In FY 2022, total actual PCI salaries of \$877,355 included \$463,339 in patient care temporary labor costs. When developing the FY 2023 budget, Shore management assumed that as COVID-related staffing pressures abated, these temporary labor costs would decline by approximately 50%. As a result of this assumption, temporary labor costs included for the PCI service line declined from \$463,339 in FY 2022 to \$245,967 in the FY 2023 budget. For the purposes of the projection, it is assumed that this amount would grow with inflation and volume through FY 2032, and not be reduced any further. Table 16 below presents the breakout of PCI permanent and temporary labor expenses for FY 2022 through the FY 2032.

Table 16
Breakout of PCI Permanent & Temporary Labor
FY2022 through FY2032

Expense	Actual FY2022	Budget FY2023	Projected			
			FY2029	FY2030	FY2031	FY2032
Permanent Labor	\$ 414,016	\$ 402,715	\$ 446,324	\$ 454,039	\$ 461,886	\$ 469,869
Temporary Labor	463,339	245,967	272,602	277,313	282,106	286,982
Total Salaries	\$ 877,355	\$ 648,682	\$ 718,926	\$ 731,352	\$ 743,993	\$ 756,852

Table of Exhibits

<u>Exhibit</u>	<u>Description</u>
18.	Updated Policy PCI-10
19.	Telemetry Monitoring Protocol
20.	Cardiac Rhythm Monitoring Protocol
21.	Annual ICU Skills Checklist
22.	Annual Telemetry Unit Skills Checklist

Table of Tables

Table	Description
Table 16	Breakout of PCI Permanent & Temporary Labor FY2022 through FY2032..... 2

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated April 28, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

May 19, 2023

Date

DocuSigned by:
JoAnne Hahey
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JoAnne Hahey, CPA
Senior Vice President and Chief
Financial Officer
University of Maryland Shore
Regional Health

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated April 28, 2023 and its attachments are true and correct to the best of my knowledge, information, and belief.

May 19, 2023

Date


DocuSigned by:

Hilary Cassel

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Hilary Cassel, MBA, BSN, RN
Regional Heart & Vascular Center
Director
University of Maryland Shore
Regional Health

EXHIBIT 18

 UNIVERSITY of MARYLAND SHORE MEDICAL CENTER AT EASTON	CARDIAC CATHETERIZATION LAB	POLICY NO:	PCI-10
		REVISED:	04/2023
	<u>PRIMARY CORONARY INTERVENTION (STEMI)</u>	PAGE #:	1 of 3
		SUPERSEDES	01/2018

Cross Reference: SRH Administrative Policy TX-103

1.0 Purpose

1.1 To facilitate and ensure the care of patients with acute ST elevation myocardial infarction (STEMI) comply with evidence based medicine and guidelines established by American College of Cardiology (ACC) and the American Heart Association (AHA). The goal is to facilitate rapid recognition and treatment of patients with STEMI such that time from medical contact to balloon time for percutaneous coronary intervention (PCI) is kept within a standard of 90 minutes or less.

2.0 Policy

2.1 There will be a dedicated staffed cardiac catheterization laboratory (Cath Lab) 24 hours per day seven days per week that will enable PCI to be performed to STEMI population.

2.2 All emergent cases take priority over scheduled cases.

3.0 Cardiac Cath Lab (CCL) Operations Providing 24 hours/day of Coverage

3.1 Normal staffed hours of operation are defined as Monday-Friday 7:00 a.m. – 5:30 p.m.

3.2 After hours of operation staffing is assured by rotating Call Teams assigned to provide coverage for all hours not covered under normal hours of operation.

3.2.1 Cardiac Cath Lab Call Team members are required to respond to the Cath Lab within thirty (30) minutes of notification (See PCI-12).

4.0 Patient Presenting to Emergency Department (ED)

4.1 When a patient presents to the ED ("walk-in") and is determined to meet STEMI criteria (See 7.0), the following will occur:

4.2 ED physician will confirm STEMI criteria and

4.2.1 Contact the Interventional Cardiologist (STEMI Cardiologist) on call and convey clinical assessment along with any diagnostic results available to include:

4.2.1.1 Allergy to Aspirin

4.2.1.2 Allergy to iodinated contrast agents

4.2.1.3 Patient on Metformin, or has a history of renal failure


4.3 Upon confirmation of STEMI, ED physician will initiate "STEMI Alert" by calling or instructing ED staff to call the Switchboard to activate "STEMI Alert." (See 8.0)

5.0 Pre Hospital Patient – Suspected STEMI

5.1 If patient is pre-hospital and is suspected of STEMI by EMS providers, EMS providers will immediately contact the ED according to MIEMSS EMS Protocol. EMS provider will transmit 12 Lead ECG via LifeNet for confirmation by ED physician.

5.2 ED physician will confirm STEMI criteria and

5.2.1 Contact the Interventional Cardiologist (STEMI Cardiologist) on call and convey clinical assessment along with any diagnostic results available to include:

 <p>UNIVERSITY of MARYLAND SHORE MEDICAL CENTER AT EASTON</p>	<p>CARDIAC CATHETERIZATION LAB</p>	<p>POLICY NO: PCI-10</p>
		<p>REVISED: 04/2023</p>
	<p><u>PRIMARY CORONARY INTERVENTION (STEMI)</u></p>	<p>PAGE #: 2 of 3</p>
		<p>SUPERSEDES 01/2018</p>

5.2.1.1 Allergy to Aspirin

5.2.1.2 Allergy to iodinated contrast agents

5.2.1.3 Patient on Metformin, or has a history of renal failure

5.3 Upon confirmation of STEMI, ED physician will initiate "STEMI Alert" by calling or instructing ED staff to call the Switchboard to activate "STEMI Alert." (See 8.0)

6.0 If patient is an inpatient, see also SRH Administrative Policy TX-103

6.1 If patient suspected of acute coronary syndrome, chest pain, or symptoms of cardiac condition, the Nurse(s) assigned to the patient will initiate "Medical Emergency Team" (MET) process (See SRH TX-103).

6.2 If following MET assessment 12 Lead ECG is not diagnostic of STEMI, patient will be placed on continuous Telemetry monitoring.

7.0 STEMI Inclusion Criteria

7.1 ST elevation of > 1mm in 2 contiguous leads.

7.2 New Left Bundle Branch Block (LBBB).

7.3 Patient is over the age of 18.

7.4 If the patient is on Metformin, there is no history of renal failure (creatinine < 1.7).

8.0 STEMI Alert Process

8.1 Once confirmation of STEMI has been determined based on patient presentations described above, the STEMI Alert process will be activated by the Hospitalist (inpatient STEMI), ED physician or the ED staff as directed by the ED physician.

8.2 The Switchboard operator will be instructed to activate the STEMI Alert process.

8.3 For all hours 24/7 the Switchboard Operator will overhead page "STEMI Alert"

8.3.1 If STEMI Alert is associated with an EMS transport ETA, the ETA will be paged along with STEMI Alert page.

8.3.2 This will serve to notify the Nursing Supervisors and Respiratory Care Practitioner and dictate immediacy of response to ED.

8.3.3 Switchboard Operator will activate the automated paging system to alert the Cardiac Cath Lab on call team to respond during hours of normal operation as well as after hours (On Call hours).

8.3.3.1 The automated paging system consists of a predetermined "scenario" that includes a text message along with a verbal message of "STEMI Alert."

8.3.3.2 The STEMI On Call Team responds as having received the message.

8.3.3.3 After hours STEMI Call Team is required to respond to CCL in 30 minutes.

8.3.4 ED physician or Hospitalist (inpatient STEMI) will call the Interventional Cardiologist on call (designated as "STEMI Cardiologist").

8.3.4.1 Interventional Cardiologist will contact the ED physician or Hospitalist (inpatient STEMI) for details of STEMI Alert.




POLICY NO:	PCI-10
REVISED:	04/2023
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SUPERSEDES	01/2018

- 8.3.5 The Switchboard will be provided with a call schedule for Interventional Cardiologist (STEMI Cardiologist) and Cardiac Cath Lab staff On Call Team.
- 8.4 Cardiac Cath Lab STEMI Response
 - 8.4.1 During normal working hours (Monday - Friday 7:00 am - 5:30pm) the CCL Team will immediately prepare one of the two procedure rooms available to accept the STEMI patient from the ED.
 - 8.4.1.1 If procedures are already under way in both Cath Labs, the Interventional Cardiologist will determine which of the two procedures can be aborted.
 - 8.4.1.2 If necessary, the patient who can be safely removed from a procedure under way will be placed in the holding area of the CCL.
 - 8.4.1.3 A CCL room will be immediately prepared to receive ED STEMI patient.
 - 8.4.2 After normal hours of operation (Monday - Friday 7:00 am - 5:30 pm) a CCL STEMI On Call Team is available.
 - 8.4.2.1 The Alert (as described 8.3.3.1) will be used to summon the On Call Team who are required to respond to the CCL within 30 minutes.
 - 8.4.2.2 Upon arrival of the On Call Team, the first member to arrive will contact the ED and let them know when CCL is preparing to accept STEMI patient.
 - 8.4.2.3 CCL Call Team will follow the predetermined sequence of room preparation (See PCI-13).
 - 8.4.2.4 Once CCL Team including Interventional Cardiologist are ready to accept STEMI patient, members of the care team will facilitate the patient's transport to the CCL.

Policy	
Effective	05/17
Revised	01/18
Revised	04/23
Policy Owner	Cardiac Cath Lab Manager

EXHIBIT 19


 UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	NURSING DEPARTMENT POLICY	POLICY NO:	NO NUMBER (TX-98)
		EFFECTIVE:	07/22
	<u>TELEMETRY MONITORING PROTOCOL</u>	PAGE #:	1 of 3
		SUPERSEDES	01/16

PURPOSE

To provide a medical staff approved nurse-driven evidence-based guide for the use of telemetry monitoring.

POLICY

- 1.0 Telemetry monitoring will be utilized only on the order of a Physician/Advanced Practice Provider (APP).
 - 1.1 The order must include documentation of indication for the telemetry monitor:
 - 1.1.1 Acute Coronary Syndrome (48 hours)
 - 1.1.2 Acute Heart Failure (72 hours)
 - 1.1.3 Antiarrhythmic Therapy with Dofetilide or Sotalol (72 hours)
 - 1.1.4 Atrial fibrillation – Uncontrolled or New Onset (48 hours)
 - 1.1.5 AV Block, High Degree – Mobitz 2 or Higher (72 hours)
 - 1.1.6 Bradycardia, Symptomatic (48 hours)
 - 1.1.7 Drug Overdose (48 hours)
 - 1.1.8 Electrolyte Imbalance, Severe – ex. K<3, Mg<1.3 (24 hours)
 - 1.1.9 EP Procedure (24 hours)
 - 1.1.10 GI Bleed, Moderate or Severe (24 hours)
 - 1.1.11 Left Main Disease, Severe (48 hours)
 - 1.1.12 Myocardial Infarction (48 hours)
 - 1.1.13 Stroke (48 hours)
 - 1.1.14 Syncope (48 hours)

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	<u>TELEMETRY MONITORING PROTOCOL</u>	PAGE #:	2 of 3
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1.1.15 Ventricular Arrhythmias (72 hours)

1.1.16 Other (24 hours)

- 1.2 When needed for the evaluation of telemetry necessity when telemetry timeframes are exceeded per protocol or evaluation of “Other” orders, the on-call cardiologist will be the daily point of contact for determination of telemetry monitoring requirements.
- 1.3 Orders with ‘Other’ selected as the telemetry monitoring indication will be further reviewed by the Chief Medical Officer/designee for appropriateness.
- 1.4 Telemetry monitoring will be discontinued by the Nurse-Driven Telemetry Monitoring Protocol or by an APP discontinuation order.


PROCEDURE

1.0 FOR PATIENTS WHO HAVE AN ORDER FOR THE TELEMETRY MONITORING PROTOCOL:

- 1.1 Nursing will evaluate the patient with a telemetry monitor 24 hours from the time of the original order and every 24 hours thereafter on the Electronic Medical Record (EMR) ‘Telemetry Assessment’ Flowsheet to determine if the patient meets criteria for continuation of telemetry monitoring.
- 1.2 If the criteria for discontinuation of telemetry monitoring are ‘Met,’ the RN will remove the telemetry monitor, notify the LIP, and document notification in the EMR ‘Telemetry Assessment’ Flowsheet.
- 1.3 After removal of the telemetry monitor, the Telemetry Unit nursing staff has the authority to transfer the patient to an appropriate Multi-Specialty Care Unit bed.

2.0 CRITERIA FOR CONTINUATION OF TELEMETRY MONITORING INCLUDE:

- 2.1 LIP documentation of CHF acute/subacute, complex cardiac disorder, IV antiarrhythmic, PO/IV antiarrhythmic load, Pro-arrhythmic meds-PHA, IV

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inotrope/chronotrope, Lifevest patient will necessitate continued telemetry monitoring.


- 2.2 Patients with a diagnosis of cerebrovascular accident (CVA), transient ischemic attack (TIA), intracerebral hemorrhage (ICH), or subarachnoid hemorrhage (SAH) will remain on the telemetry unit, regardless of telemetry monitoring status.
- 2.3 Documentation of a significant change in clinical status or Vital Signs that meet the below parameters in the 8 hours prior to The Clinical Review.
 - 2.3.1 Significant Change in Clinical Status is defined as a change with serious arrhythmias or clinical deterioration.
 - 2.3.2 Systolic BP <90mmHg, Heart Rate >120 or < 45 bpm, Respiratory Rate >28 or <8.

SRH Administrative Policy	
Effective	01/06/16
Approved	Medical Executive Committee:01/06/16
Nursing Policy	
Revised	07/22
Approved	Medical Executive Committee: 08/22
Policy Owner	Mandy Bounds DNP, RN, CCRN, CPHQ Director Acute and Critical Care Services

REFERENCES

1. Clapp, R. (2022). Nurse-driven protocol to reduce unnecessary telemetry use. *MEDSURG Nursing*, 31(2), 83-86.
 2. Drew, et al. (2004) AHA Scientific Statement: Practice Standards for Electrocardiographic Monitoring in Hospital Settings. *Circulation*, 2721-2746.
 3. Dripps, H. (2020). The beat stops here: a nurse-driven protocol to manage telemetry orders. Otterbein University.
 4. Pendharkar, S., et al. (2020). AHA telemetry guidelines improve telemetry utilization in the inpatient setting. *The American Journal of Managed Care*, 26(11), 476-481.
 5. Rotramel, R. (2021). Reducing overuse of telemetry. *American Nurse Journal*, 16(7).
 6. Sandau, K., et al. (2017). Update to practice standards for electrocardiographic monitoring in hospital settings. *Circulation*, 136, e273-e344.
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EXHIBIT 20

 UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	CRITICAL CARE DEPARTMENT	POLICY NO:	
		REVIEWED:	08/22
	<u>CARDIAC MONITORING</u>	PAGE #:	1 of 6
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PURPOSE: *To outline the nursing and monitor technician (MT)/designee responsibilities in the use of bedside cardiac monitoring and central cardiac monitoring for patients at Shore Regional Health.*

SCOPE: RN, Monitor Technician/Designee

DEFINITIONS:

Remote Telemetry Monitoring: *Transmission of cardiac signals to a receiving location where they are displayed for monitoring.*

Bedside Cardiac Monitoring: *A cardiac monitor located inside the patient's room to continuously measure and display cardiac rhythm for monitoring.*

Central Cardiac Monitoring: *A cardiac monitor located in a centralized location. This location may vary per unit/department*

Monitor Technicians/Designee: *Monitor patients cardiac rhythm wave forms, interprets the rhythms, dysrhythmias, and ectopy. Communicates information (including changes) to appropriate staff as outlined in this policy.*

POLICY:

1.0 *University of Maryland Shore Regional Health at Easton*


1.1 *Patients on the Telemetry Unit and 3 East shall be monitored by monitor technicians (MT)/designee from the Telemetry Unit.*

2.0 *University of Maryland Shore Regional Health at Chestertown.*

2.1 *Monitoring capability on the Acute Care Unit will be at bedside and/or centralized monitoring.*

3.0 All patients with orders for admission to the ICU or Telemetry will have ongoing cardiac monitoring.

3.1 Exception: Patients on the Telemetry unit may only be removed from cardiac monitoring with a Physician or Advanced Practice Provider (APP)


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order, in accordance with the Telemetry Monitoring Protocol, and/or in accordance with the Critical Care Policy for Transportation of Monitored Patients Off Unit for Procedures.

- 3.2 ICU patients must be accompanied by a qualified nurse (in addition to continuous cardiac monitoring) when off the unit for testing.
- 3.3 The monitors will be observed by a staff member competent in dysrhythmia interpretation.
- 3.4 The Physician or APP will be notified when patients with orders for telemetry monitoring refuse continuous cardiac monitoring; the Physician/APP will discuss risks/benefits of treatment with the patient, as appropriate. Patients who do not meet criteria for Telemetry Monitoring will be removed from cardiac monitoring, in accordance with the Telemetry Monitoring Protocol. If telemetry is indicated and a patient still declines telemetry monitoring, documentation of refusal for recommended therapy and/or decision to leave AMA will be documented.

4.0 Monitoring of Patients

- 4.1 Heart rate and arrhythmia alarms will be on at all times and set appropriately for patient's clinical status within one hour of admission to the unit.
- 4.2 ECG pattern will be evaluated through observation and alarm parameters
- 4.3 Leads II or V1 will be routinely used for cardiac monitoring.
 - 4.3.1 Lead selection may be changed on an individual basis for optimal visualization.
- 4.4 Patient's last name and Medical Record number will be entered into the cardiac monitoring system on all patients.
- 4.5 Rhythm strips will be documented noting rhythm, rate, PR interval, QRS, and QT Interval and any ectopy when:
 - 4.5.1 Telemetry transmitter applied

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4.5.2 As needed for rhythm changes

4.5.3 Every 8 hours

4.5.4 When medications specifically designed to control rate and/or rhythm are administered

4.6 All cardiac rhythm interpretations performed by a monitor technician/designee will be verified by a nurse competent in dysrhythmia interpretation. The RN will document in the patient's medical record that they have verified the patient's cardiac rhythm interpretation at least every 8 hours, or with any change in rhythm.

4.7 Electrode integrity will be assessed periodically and changed as needed.

5.0 Alarm Parameters

5.1 Heart rate alarm parameters will be **based on the assessment of the patient's condition and** evaluated at least every 8 hours or with significant changes in rhythm or rate.


5.2 Heart rate alarm parameters will be maintained at 30 BPM above and below patient's current rate. (Alarm parameters will be maintained closer to the patient's actual heart rate if bradycardia.
Example: Patient's HR=40, low alarm limit will be set at 30).

5.3 Alarm volumes will be maintained at an audible level at all times.


5.4 At no time should cardiac monitors be silenced, turned off or turned down to an ineffective auditory level, unless the patient has left the unit, however, bedside alarms may be temporarily silenced in the patient's room when comfort or end-of-life care is being provided.

6.0 Cardiac Monitor Alarm Levels and Management

6.1 When applicable, the monitor technicians (MT)/designee will immediately notify the patient's nurse or charge nurse of changes in cardiac rhythm and/or significant heart rate changes.

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- 6.2 Clinically significant changes in heart rhythm or rate or in hemodynamic status will be communicated to the Physician/APP immediately.
- 6.3 Upon notification of a Red Level Alarm/High Alarm Priority alarm, the MT/designee will immediately activate a Code Blue to the patient's location.
- 6.3.1 Red Level Alarms/ High Alarm Priority alarms require immediate response and include:
- 6.3.1.1 Ventricular Fibrillation/Ventricular Tachycardia
- 6.3.1.2 Asystole
- 6.4 Upon notification of a Yellow Level /Medium Priority alarm, the MT/designee will notify the primary RN of the rhythm change, cardiac event, and/or monitor off patient by phone immediately as the event occurs. A strip of the event will be recorded and documented on the strip sheet. The patient's primary nurse will assess the patient's status immediately.
- 6.4.1 Yellow Level/Medium Priority alarms require a prompt response and include rhythm changes and cardiac event changes that require prompt response (examples - High/Low Heart rate alarms, SpO2 Low, Apnea alarm, VT>2 beats, Idioventricular rhythm, Accelerated Idioventricular rhythm, Pause)
- 6.5 **Escalation Process:** To be followed by MT/designee any time original contact attempt is unsuccessful or if a response/action delay of 2 minutes is being experienced for patient being off the monitor/yellow level/medium priority alarms:
- 6.5.1 To be followed by MT/designee any time original contact attempt is unsuccessful or if a response/action delay of 2 minutes is being experienced for patient being off the monitor


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6.5.1.1 The primary nurse will be notified that a patient is off the monitor or the patient's rhythm change requires prompt notification. The date and time of the notification, along with the nurse's name will be documented. Resolution of the issue will be documented.

6.5.1.2 If the MT/designee is unable to get in contact with the primary nurse after 2 attempts and after 2 minutes, the MT will call the charge nurse. If the patient's rhythm has not returned or the patient is not placed back on the monitor within 2 minutes of the charge nurse notification OR the charge nurse has not communicated a reason for the patient being off the monitor or management of the rhythm change has not been addressed, the nurse manager/designee or nursing supervisor will be notified. The centralized MT will consider other staff available to respond to the patient's bedside.

6.6 MTs/designee may not change alarm parameters without approval of the RN caring for the patient.

7.0 Competency of staff responsible for cardiac monitoring will have dysrhythmia identification competency validated on an annual basis.

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Policy	
Effective	09/01
Revised/ Reviewed	08/22; 01/22; 08/17; 01/13; 04/09; 06/07; 07/06; 03/05; 08/03; 10/02; 11/01
Approved	Critical Care Committee: 07/22
Approved	Medical Executive Committee: 08/22
Policy Owner:	Critical Care Team
SPIRIT Form	Pam Pardun 08/17

REFERENCE:

1. University of Maryland Shore Regional Health Telemetry Monitoring Protocol
2. American Association of Critical Care Nurses. (2017). AACN Protocol for Practice – Bedside Cardiac Monitoring.
3. American Association of Critical Care Nurses. (2018). AACN Practice Alert: Managing alarms in acute care across the lifespan: Electrocardiography and pulse oximetry. *Critical Care Nurse*, 38(2), e16-e20.
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EXHIBIT 21

**University of Maryland Shore Regional Health
Critical Care Registered Nurse- ICU Skills Checklist**

Name _____ Employee # _____

Instructions:

- Preceptor to place validation code, date/initials in boxes as appropriate.
- The Orientee is not to perform any skill independently that has not been validated by either preceptor or another qualified RN (staff RN from that unit, Clinical Nurse Educator, Specialty Educator, Clinical Nurse Coordinator, Unit Manager, or Administrative Supervisor).
- If a skill is not applicable to the Unit to which the Orientee is being oriented, place “N/A” in the columns for that item.
- Each box must be dated and initialed separately. **It is not acceptable to draw arrows to indicate a date and initials for multiple boxes.**
- Any person who initials a box must complete the initial/signature section on the last page.
- **At least 85% of the Orientation Checklist must be completed, and documentation must be submitted to the Nurse Manager before the Orientee is released from orientation.**
- 100% must be complete by the employee’s annual evaluation

*****One copy when complete to unit manager and one copy sent to HR**

COMPETENCY VALIDATION - Employee is able to demonstrate correctly the following components of care by: 1. Direct Observation 2. Simulation 3. Case Study/Case Scenario 4. Written Exam 5. Exemplar 6. Class 7. Self-Learning Module	Competency Validation code	Performed with supervision Preceptor and orientee to initial and date	Performed independently Preceptor and orientee to initial and date
12 Lead EKG with bedside and portable machine			
GE monitor <ul style="list-style-type: none"> • Admission/discharge • Alarms and other functions 			
ABG analysis			
Accompanying monitored patient off the unit for a procedure			
Assisting in invasive bedside procedures <ul style="list-style-type: none"> • Bedside verification procedure 			
Blood warmer			
Care of patients with arterial line <ul style="list-style-type: none"> • Assist with insertion • BP measurement/waveform • Maintenance • Blood collection • Removal 			

Care of patients with central line <ul style="list-style-type: none"> • Assist with insertion • CVP measurement/waveform • Maintenance • Blood collection • Removal (PICC and non-tunneled) 			
Care of patients with Swan-Ganz <ul style="list-style-type: none"> • Assist with insertion • PA/Wedge waveform • Cardiac output • Maintenance • Blood collection • Assist with removal 			
Care of mechanically ventilated patients <ul style="list-style-type: none"> • Assist with intubation • ABCDE Bundle • Sedation administration, RASS • ETT/Trach size, ventilator settings and alarms • Weaning and extubation 			
Care of patients with chest tubes			
Care and preparation of a pre-op patient			
Care and assessment of a post- op patient			
Care of the patient experiencing chest pain			
Care of patient experiencing a cardiac Dysrhythmia <ul style="list-style-type: none"> • Cardiac monitor policy 			
Care of patients in cardiac arrest			
Care of patients with STEMI			
Care of patients with IABP			
Care of patient pre and post cardiac catheterization			
Care of patients pre and post PCI <ul style="list-style-type: none"> • Radial access care and closure devices • Femoral access care and closure devices 			
Care of the patient experiencing a code white <ul style="list-style-type: none"> • Blood transfusion process • Use of rapid infuser 			
Care of the patient experiencing a stroke, including BAT and NIHSS			

Care of patients on targeted temperature management <ul style="list-style-type: none"> • Temperature regulating devices • Peripheral Nerve Stimulation (Train of Four) 			
Care of the patient pre and post- permanent pacemaker insertion			
Care of the patient with hyper/hypoglycemia <ul style="list-style-type: none"> • DKA and insulin infusion • Use of glucometer 			
Care of the patient requiring synchronized cardioversion			
Care of the patient with BIPAP, CPAP and high flow nasal cannula			
Care of the patient with Sepsis			
Care of the patient with transcutaneous pacing			
Care of the patient needing transvenous pacing			
Care of patients with CRRT			
Care of post-op neurosurgical patients <ul style="list-style-type: none"> • ICP monitoring • Lumbar EVD 			
Care of patient with tube feeding <ul style="list-style-type: none"> • Management of OGT/NGT/PEG • Tube feeding pump 			
Datascope vital sign machine			
Demonstration of medication administration process			
Demonstration of performance and documentation of physical assessment <ul style="list-style-type: none"> • Neuro • Cardiac • Respiratory • Gastrointestinal • Genitourinary • Integumentary 			
Donning and Doffing <ul style="list-style-type: none"> • Contact isolation • Droplet isolation • Airborne isolation • COVID 			

Fall prevention equipment (lift equipment)			
Fecal Management system Flexi-Seal			
Infusion Pump			
Intravenous Insertion			
Intraabdominal pressure measurement			
IV fluid and medication administration, including administration set change			
Lab specimen collection and labeling			
Living legacy (Care of Donor patient)			
Management of patients at risk for suicide, <ul style="list-style-type: none"> • Low risk • Moderate risk • High risk • Continuous observation flowsheet and documentation 			
Moderate sedation and capnography			
Patient requiring Aquapheresis			
Patient with Peritoneal Dialysis			
Patient undergoing TEE			
Palliative care patients			
Proning			
Restraints Documentation and Orders (TX-02) <ul style="list-style-type: none"> • Non-Violent TX 02 A • Violent TX 02 B • Demonstration of quick release knot 			
Rhythm strip recognition, verification and documentation			
Temperature regulating devices			
Tracheostomy care <ul style="list-style-type: none"> • Suctioning with in-line suction • Suctioning with sterile kit 			
Transfusion of blood products (consent, administration, procedure for reaction)			
Use of specimen trap for sputum specimen			
Venipuncture			
Wound VAC			
ECARE			
Medications to include dosage calculation, titration and monitoring			
Adenosine			
Alteplase			

Albumin			
Amiodarone			
Angiomax			
Ativan			
Cardizem			
Dobutamine			
Dopamine			
Epinephrine			
Esmolol			
Flumazenil			
Heparin			
Insulin			
Integrilin			
Ketamine			
Lasix			
Lidocaine			
Levophed/ Norepinephrine			
Neo-Syneprine			
Nitroglycerine			
Nitroprusside			
Nicardipine			
Narcotic infusions(fentanyl, morphine)			
Naloxone			
Octreotide			
Precedex			
Propofol			
Tenecteplase			
Vasopressin			
Versed			
NMBAs(Vecuronium, Cisatracurium, Rocuronium)			
TPN/PPN			
Initials	Signature	Initials	Signature

Update approved 5/2020
Critical Care Policies
AACN Procedural Manual
Online Lippincott Resources

EXHIBIT 22

**University of Maryland Shore Regional Health @ Easton
Telemetry Registered Nurse- Skills Checklist**

Name _____ Employee # _____

Instructions:

- Preceptor to place validation code, date/initials in boxes as appropriate.
- The Orientee is not to perform any skill independently that has not been validated by either preceptor or another qualified RN (staff RN from that unit, Clinical Specialist, Specialty Educator, Clinical Nurse Coordinator, Unit Manager, or Administrative Supervisor).
- If a skill is not applicable to the Unit to which the Orientee is being oriented, place “N/A” in the columns for that item.
- Each box must be dated and initialed separately. **It is not acceptable to draw arrows to indicate a date and initials for multiple boxes.**
- Any person who initials a box must complete the initial/signature section on the last page.
- At least 85% of the Orientation Checklist must be completed, and documentation must be submitted to the Nurse Manager before the Orientee is released from orientation.
- 100% must be complete by the employee’s annual evaluation

COMPETENCY VALIDATION - Employee is able to demonstrate correctly the following components of care by: 1. Direct Observation 2. Simulation 3. Case Study/Case Scenario 4. Written Exam 5. Exemplar 6. Class 7. Self-Learning Module	Competency Validation Code	Performed with supervision Preceptor and orientee to initial and date	Performed independently Preceptor and orientee to initial and date
12 Lead EKG			
Accompanying monitored patient off the unit for a procedure			
Care of patients with central line <ul style="list-style-type: none"> • Assist with insertion • Dressing change and maintenance • Blood collection • Removal(PICC and Non tunneled) 			
Assisting in bedside procedures <ul style="list-style-type: none"> • Bedside verification procedure 			
Care of patients with chest tubes			
Care and preparation of a pre- op patient			
Care and assessment of a post-op patient			
Care of the patient experiencing chest pain			
Care of patient experiencing a cardiac dysrhythmia			
Care of patient with STEMI			
Care of the patient pre and post cardiac catheterization			
Care of patients pre and post Percutaneous Coronary Intervention)PCI			

<ul style="list-style-type: none"> • Radial access care and closure devices • Femoral access care and closure devices 			
Care of the patient experiencing a stroke, including BAT and NIHSS			
Care of the patient pre and post- permanent pacemaker insertion			
Care of the patient requiring synchronized cardioversion			
Care of the patient undergoing nuclear stress test			
Care of the patient with hypo/hyperglycemia <ul style="list-style-type: none"> • DKA and insulin infusion • Use of glucometer 			
Care of the patient with Bi-Pap , C-Pap, and High flow nasal cannula			
Care of patients with sepsis			
Care of patients with tube feeding <ul style="list-style-type: none"> • Management of OGT/NGT/PEG • Tube feeding pump 			
Data scope vital sign machine			
Demonstration of medication administration process			
Demonstration of performance and documentation of physical assessment <ul style="list-style-type: none"> • Neuro • Cardiac • Respiratory • Gastrointestinal • Genitourinary • Integumentary 			
Donning and Doffing <ul style="list-style-type: none"> • Contact isolation • Droplet Isolation • Airborne Isolation • COVID 19 • EBOLA 			
Fall Prevention/lift Equipment			
Fecal management system - Flexi-Seal			
Infusion pump			
Intravenous insertion			
IV fluid and medication administration, including administration set change			

Lab specimen collection and labeling			
Management of patients at risk for suicide <ul style="list-style-type: none"> • Low risk • Moderate risk • High risk • Continuous observation flowsheet and documentation 			
Moderate sedation and capnography, including sedation narrator			
Patient requiring Aquapheresis			
Patient with peritoneal dialysis			
Patient undergoing TEE			
Palliative Care patients			
Restraints Orders and documentation(TX-02) <ul style="list-style-type: none"> • Non-Violent • Violent • Observation flowsheet • Demonstration of quick release knot 			
Rhythm strip recognition, verification, and documentation			
Temperature regulating devices			
Tracheostomy care <ul style="list-style-type: none"> • use of sterile suction kit • stoma site care • changing inner cannula 			
Transfusion of blood products (consent, administration, procedure for reaction)			
Use of specimen trap for sputum specimen			
Venipuncture			
Wound VAC			
Medications			
Adenosine			
Amiodarone			
Ativan			
Brilinta			
Cardizem			
Coumadin			
Digoxin			
Dilaudid			
Dopamine non titrating			

Dobutamine non titrating			
Eliquis			
Flumazenil			
Heparin (subcutaneous and IV infusion)			
Hydralazine			
Hydromorphone			
Insulin			
Integrilin			
Labetalol			
Lasix			
Lopressor			
Lovenox			
Magnesium sulfate			
Midazolam			
Morphine			
Naloxone			
Nitroglycerin IV(non titrating bridge to Cath lab/ICU)			
Nitroglycerin Sublingual			
Octreotide			
Plavix			
Potassium IV			
TPN/PPN			
Tylenol IV			
Vitamin K			
Xarelto			
Initials	Signature	Initials	Signature

Update approved 10/2020
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