TRI-CITY HEALTHCARE DISTRICT **REVISED**
AGENDA FOR A REGULAR MEETING
January 26, 2017 – 1:30 o'clock p.m.
Classroom 6 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2, 3
4002 Vista Way, Oceanside, CA 92056

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	**2 Hours**	
	a. Conference with Labor Negotiators: (Authority: Government Code, Section 54957.6) Agency Negotiator: Steve Dietlin Employee organization: CNA		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets: New Facilities; Conference with Real Property Negotiators (Authority: Health and Safety Code, Section 32106, Gov. Code Section 54956.8) Property: 4002 Vista Way, Oceanside, CA 92056 Agency Negotiator: Steve Dietlin Negotiating Parties: Tri-City Healthcare District and United States Under Negotiation: Development program Date of disclosure: February 28, 2017		

Note: Any writings or documents provided to a majority of the members of Tri-City Healthcare District regarding any item on this Agenda will be made available for public inspection in the Administration Department located at 4002 Vista Way, Oceanside, CA 92056 during normal business hours.

Note: If you have a disability, please notify us at 760-940-3347 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
	d. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) (3 Matters)		
	e. Approval of prior Closed Session Minutes		
	f. Public Employee Evaluation: General Counsel (Authority: Government Code, Section 54957)		
	g. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) Medical Acquisitions Company vs. TCHD Case No: 2014-00009108 (2) TCHD vs. Medical Acquisitions Company Case No: 2014-00022523 (3) Larry Anderson Employment Claims		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Board Recognition of Outstanding Service – J. Johnson, Director of Marketing and Marketing Team	10 min.	Chair
13	Community Update – 1) Patient Safety Summit Video – Sharon Schultz, CNE 2) Flu Update – Sharon Schultz, CNE	 5 min. 5 min.	 CNE CNE
14	Report from TCHD Auxiliary – Pat Morocco, Vice President	5 min.	Standard
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Acting Chief Financial Officer	10 min.	Standard
17	New Business		
	a. Media Update – Information Only	5 min.	Chair

	Agenda Item	Time Allotted	Requestor
	b. Consideration to approve Resolution No. 781, A Resolution of Tri-City Healthcare District Authorizing Borrowing	5 min.	Chair
	c. Consideration of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings	5 min.	Gov. & Leg Comm.
	d. Consideration of Board Policy 16-040 – Activities for which Board Compensation is Available	5 min.	Gov. & Leg. Comm.
	e. Consideration to direct the Governance & Legislative Committee to develop a policy relative to contract approval process by the Board	5 min.	Director Reno
	f. Consideration of Board Policy 15-013 – Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services and Bidding for Public Works Contracts	5 min.	Director Reno
	g. Consideration to appoint Ms. Linda Ledesma, Ms. Xiomara Arroyo and Ms. Marilou de la Rosa Hruby to an additional two-year term on the Community Healthcare & Alliance Committee as recommended by the committee.	5 min.	Chair
18	Old Business a. Report from Ad Hoc Committee on electronic Board Portal	5 min.	Ad Hoc. Comm.
19	Chief of Staff a. Consideration of January 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals b. Privilege Cards: 1) Neurosurgery	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 0 *No meeting held in January, 2017* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 3	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	(Committee minutes included in Board Agenda packets for informational purposes)		
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)*		FO&P Comm.
	a. Approval to add Dr. Sharona Ben-Haim to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months beginning January 1, 2017 through December 31, 2017.		
	b. Approval to add Dr. Pamela Jones to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning January 1, 2017 through December 31, 2017.		
	c. Approval to add Dr. Erik Stark to the existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 18 months, beginning January 1, 2017 through June 30, 2018.		
	d. Approval of an agreement with Coastal Hospitalists for five (5) months, beginning February 1, 2017 through June 30, 2017 for a daily rate of $875, a monthly cost of $26,250 and a total term cost of $131,250.		
	e. Approval of an agreement with Dr. Mohammad Ahmed, Medical Director for the BHU for 12 months beginning February 1, 2017 through January 31, 2018, not to exceed 40 hours for the month, at an hourly rate of $150, for a monthly cost of $6,000 and a total cost for the term of $72,000.		
	f. Approval of an agreement with Dr. Mohammad Ahmed, Medical Director for the Crisis Stabilization Unit for 12 months, beginning February 1, 2017 through January 31, 2018, not to exceed 40 hours per month, at a hourly rate of $150, for a monthly cost of $6,000 and a total cost for the term of $72,000.		
	g. Approval of an agreement with Dr. Venugopal DePala, Covering Physician for the BHU for 12 months, beginning February 1, 2017 through January 31, 2018, not to exceed 10 hours per month, at an hourly rate of $150, for a monthly cost of $1,500 and a total cost for the term of $18,000.		
	h. Approval of an agreement with Dr. Venugopal DePala, Covering Physician for the Crisis Stabilization Unit for 12 months, beginning February 1, 2017 through January 31, 2018, not to exceed 10 hours per month, at an hourly rate of $150, for a monthly cost of $1,500 and a total cost for the term of $18,000.		
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)*		PAC

	Agenda Item	Time Allotted	Requestor

1) Patient Care Services

a. Abduction Shoulder Splint Procedure
b. Abduction Splint Application (HIP) Procedure
c. Allied Health Students in Patient Care Areas Policy
d. Cardioversion, Elective Procedure
e. Continuous Passive Motion (CPM) Machine Procedure
f. Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure
g. Fall Risk Procedure and Score Tool Procedure
h. Interpretation and Translation Services
i. Medication Reconciliation Policy
j. Neutropenic Precautions Policy
k. Nursing Students in Patient Care Areas Policy
l. Surgical Skin Stapling
m. Swallowing, Food and Nutrition Considerations for Patients with Oropharyngeal Dysphagia Policy

2) Administrative Policies & Procedures

a. Decorative Materials #248

3) Unit Specific

A. Emergency Operations Procedure (EOP) Manual
Formerly Disaster Manual

1. Emergency Operations Plan

B. Engineering
1. Equipment Repair
2. Maintenance and Inspection Medical Gas 2003
3. New Equipment Inventory and Inspection 2007
4. Pre-Purchase Evaluations 2009
5. Purchasing Procedure 2011
6. Scheduled Equipment Maintenance 2006
7. Utility Management Plan 4003
8. Work Order Requests 2010

C. Environment of Care Manual
1. Fire Safety Hazards
2. Hazardous Material and waste Management and Communication Plan
3. Life Safety Management Plan
4. Medical Equipment Management Plan
5. Safety Plan
6. Security Management Plan

D. Infection Control
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan
2. Standard and Transmission-Based Precautions
3. Waterborne Illness
4. Zika Virus

E. Medical Staff
1. Disaster Privileges

F. Neonatal Intensive Care

	Agenda Item	Time Allotted	Requestor
	1. Amphotericin-B Liposome (AmBisome), Ordering and Infusion of 2. Consultation to Perinatal Unit G. Women & New Born Services 1. Epidural Spinal Block Management 2. Laminaria 3. Scheduling Process for Procedures 4. Shift Change Responsibilities 5. Vacuum Extractionborn Services H. Formulary Requests 1. Formulary Line Item Deletions a. Albuterol Tablets b. Erythromycin/ Sulfixoxazole 200mg/600 mg suspension c. Formoterol 12 mcg (Foradil Aerolizer) 2. Admission to Formulary - Zarxio		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 2 *(Committee minutes included in Board Agenda packets for informational purposes)* 1. Medical Staff Rules & Regulations: a) Division of Subspecialty Surgery 2. Approval of Committee Charters: a) Governance & Legislative Committee b) Employee Fiduciary Subcommittee c) Finance, Operations & Planning Committee 3. Approval of Board Policy 14-009 – Requests for Information or Assistance by Board Members		Gov. & Leg. Comm.
	G. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 1 *(Committee minutes included in Board Agenda packets for informational purposes.)* 1) **<u>Administrative Policies & Procedures</u>**: a. #8610-561 – Responding to Compliance Issues – Reports of Suspected Misconduct Investigation 2) Approval to direct management to seek proposal for FY2017 Financial Statement Audit from Moss Adams		Audit, Comp. & Ethics Comm.
	(2) Minutes – Approval of: a) Regular Board of Directors Meeting – December 8, 2016 b) Special Board of Directors Meeting – December 15, 2016 c) Special Board of Directors Meeting – December 15, 2016 d) Special Board of Directors Meeting – December 20, 2016		Standard

	Agenda Item	Time Allotted	Requestor
	(3) Meetings and Conferences a) CHA Legislative Days – March 15-16, 2017– Sacramento, CA b) HCCA Board Audit Committee Compliance Conference – February 27-28, 2017 – Scottsdale, AZ (4) Dues and Memberships - a) Governance Institute Membership - $23,475.00		Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – Included (c) Lease Report – (December, 2016) (d) Reimbursement Disclosure Report – (December, 2016) (e) Seminar/Conference Reports - None	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3 hours	
28	Oral Announcement of Items to be Discussed During Closed Session		
29	Motion to Return to Closed Session (if needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #16-010

POLICY TITLE: Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson

I. BOARD MEETING AGENDA DEVELOPMENT

The Board of Directors Agenda shall be developed by the Chairperson, with the assistance of the President/CEO and General Counsel. Individual Board members may place items on the Agenda through the Board Chairperson. The procedure will be:

A. A Board member shall submit a written description of the Agenda item to the Chairperson or the CEO or the Board Secretary, prior to the time of the Agenda Conference. Recognizing that the Agenda Conference meeting date and time may on occasion change, it is the responsibility of the requestor to confirm the Agenda Conference meeting date to ensure timely submittal of the requestor's Agenda item. Discussion items will be placed on the Board Agenda at the request of any Board member. At the beginning of each calendar year, the Chairperson of the Board of Directors shall set the date and time of the Agenda Conference.

B. A member of the public may submit a written request to the President/CEO, Chairperson or a member of the Board of Directors. The written request shall contain a description of the Agenda item. The member of the public shall be informed if and when the item will appear on the Board Agenda.

C. General Counsel, at the Chairperson's or President/CEO's request, shall contact the Board member, or the public member, to confirm the intent of their request, and will then formulate the Agenda item in a format that conforms with legal requirements.

D. Copies of the Agenda shall be posted on the TCHD website and at other public locations as required by law.

II. EFFICIENCY OF BOARD MEETINGS

The Board of Directors and management shall work cooperatively to prepare for and manage Board meetings in a manner that produces efficient and effective meetings (See Policy #10-39). To achieve that end, the following process will be followed:

A. The Board of Directors shall receive their Board Agenda packet with appropriate written information and materials at least five (5) days prior to a regularly scheduled Board of Directors meeting.

B. Board members who require further information or clarification on Board Agenda packet materials are welcome to contact the President/CEO or General Counsel

with questions prior to the meeting. Responses shall be presented to all Board members at the Board meeting.

C. To facilitate deliberation and action on items at Tri-City Healthcare District Board of Directors meetings, suggested written motions may be developed in advance by members of the Board of Directors or Executive Management. Such suggested written motions shall be included in the Board of Directors Agenda packet with supporting materials for the action item.

III. TIME LIMITS FOR BOARD OF DIRECTOR MEETINGS

A. Regular meetings of the Board of Directors shall be a maximum of three and one half (3½) hours for any open session and a maximum of four hours (4) for any closed session. Agenda items not addressed during those time periods will be carried forward to a subsequent date, which shall be agreed upon by a majority vote of the Board before adjourning the meeting.

B. The time limits under Section A may be waived by a majority of the Board. The waiver shall be effective only for the meeting in which the waiver is approved. A motion for waiver may specify that the limit will be waived entirely for the balance of the session, will be extended for a specified amount of time of at least one-half (1/2) hour, or will be extended only for so long as the Board requires to address one or more specified items on the Agenda for that session.

IV. ROLE AND POWERS OF CHAIRPERSON

The Chairperson of the Board of Directors shall have the authority to act on behalf of the Board of Directors, as provided in the District Bylaws and these policies.

The Board Chairperson shall report any such actions to the Board of Directors at their next regularly scheduled meeting.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Received by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Revised by the Gov/Leg Committee: 8/4/15
Approved by the Board of Directors: 8/27/15
Reviewed by the Gov/Leg Committee: 8/02/16
Approved by the Board of Directors: 8/25/16

Topic	Discussion	Action Follow-up	Person(s) Responsible

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e. Review and discussion of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson	Director Reno stated Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson was placed on today's agenda to discuss agenda development and placement of items on the Consent Agenda. Mr. Moser explained items that come before the Board are controlled by statute. The Consent agenda was implemented as an efficient way to do business. The question was raised as to who decides which items are placed on the Consent agenda rather than under new Business. Mr. Moser stated that determination is made at the agenda conference which is attended by General Counsel, Mr. Dietlin, the Board Chair and the Executive Assistant. The question was also raised as to whether any Board member can attend the agenda conference. Mr. Moser stated Board members are not prohibited from attending the agenda conference however their role would be strictly as a guest and per the Brown Act there cannot be a quorum of Board members at the agenda conference. Discussion was held regarding the ways in which items on the Consent Agenda can be open for discussion. 1) Items that appear on the Consent Agenda have gone to the applicable Board Committee during the current month. Board Committee packets are sent to all Board members whether they sit on the committee or not and the entire packet is also posted on the District's website for public purview. 2) Board committee meetings are open to public where agenda items are discussed in detail. 3) Recommendations for approval from the Board Committees are brought forward to the Board as a whole and placed either on the Consent Agenda or New Business at the discretion of the Chair. 4) The entire Board packet is posted on the District's website at least 72 hours prior to the meeting for public purview. If further discussion is desired on a Consent Agenda item, the Board member has the ability to pull the item with a "second" for discussion. In addition, community members may complete a Speaker Card to comment on		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	any item on the agenda. **It was moved by Director Reno to recommend approval of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson as written and placed under New Business on the Board agenda. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson, item to be placed on Board Agenda New Business and included in Board agenda packet.	Ms. Donnellan
f. Review and discussion of Board Policy 16-040 – Activities for Which Board Compensation is Available	Director Reno stated she requested Board Policy 16-040 – Activities for Which Board Compensation is Available be placed on today's agenda to discuss a potential stipend for Board member attendance at the designated Auxiliary and Foundation monthly Board meetings. Director Reno stated the designated Board member attends the Auxiliary and Foundation Board meeting as an advisory party, rather than a guest and therefore should be compensable. It was noted attendance by Board Members at MEC would not be compensable as the Board member is purely a guest. It was suggested the policy be revised to reflect that "attendance at meetings of the Tri-City Hospital Auxiliary and Tri-City Hospital Foundation at the request of the Chair of the Board shall be compensated, provided that the meeting is at least 30 minutes in length, the Director is physically present during the meeting for not less than 30 minutes and further provided that compensation is limited to fifty ($50) per meeting". Discussion was held regarding reimbursement for participation via teleconference. Mr. Moser stated no compensation is provided via teleconference from a location which is not a location open to the public per the Brown Act and within the jurisdiction. **It was moved by Dr. Ma to recommend approval of amendments to Board Policy 16-040 – Activities for Which Compensation is Available as described. Director Reno seconded the motion. The motion**	Recommendation to be sent to the Board of Directors to approve amendments to Board Policy 16-040 – Activities for Which Compensation is	Ms. Donnellan

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #16-040

POLICY TITLE: Activities for Which Board Compensation Is Available

When compensation has been authorized by Board Resolution, pursuant to Health & Safety Code section 32103, such compensation may be paid in accordance with Article III, section 4 of the Bylaws of the District and this policy. Compensation is limited to one hundred dollars ($100) per meeting (except as noted below), not to exceed five meetings per month. The following are compensable activities:

1. Attendance at a regular, special or emergency meeting of the Board of Directors shall be compensable, provided the meeting is at least 30 minutes in length, and the Director seeking compensation is present during the meeting for not less than 30 minutes.

2. Attendance at any meeting of a standing or ad hoc committee of the Board of Directors shall be compensable, provided that the meeting is at least 30 minutes in length, the Director is a member of the committee and is present during the meeting for not less than 30 minutes.

3. Attendance at meetings of the Tri-City Hospital Auxiliary and Tri-City Hospital Foundation at the request of the Chair of the Board shall be compensation, provided that the meeting is at least 30 minutes in length, the Director is physically present during the meeting for not less than 30 minutes, and further provided that compensation is limited to fifty ($50) per meeting.

No compensation shall be available, however:

1. For attendance via teleconference from a location which is not a location open to the public per the Brown Act and within the jurisdiction.

2. For attendance at a committee meeting in which the Board member is not a member of the committee.

3. Unless the minutes of the meeting or other written evidence reflects a Director's attendance in compliance with this policy.

4. If compensation is limited under any other Board policy, including, but not limited to Board Policy #010-020 and #010-038.

5. If the Director does not request compensation in writing within 180 days of attending the meeting for which compensation may be paid.

Reviewed by the Gov/Leg Committee: 8/10/05

Approved by the Board of Directors: 9/22/05
Approved by the Board of Directors: 3/25/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 6/07/16
Approved by the Board of Directors: 6/30/16
Reviewed by the Gov/Leg Committee: 1/3/17
Approved by the Board of Directors:

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	any item on the agenda. **It was moved by Director Reno to recommend approval of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson as written and placed under New Business on the Board agenda. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson; item to be placed on Board Agenda New Business and included in Board agenda packet.	Ms. Donnellan
f. Review and discussion of Board Policy 16-040 – Activities for Which Board Compensation is Available	Director Reno stated she requested Board Policy 16-040 – Activities for Which Board Compensation is Available be placed on today's agenda to discuss a potential stipend for Board member attendance at the designated Auxiliary and Foundation monthly Board meetings. Director Reno stated the designated Board member attends the Auxiliary and Foundation Board meeting as an advisory party, rather than a guest and therefore should be compensable. It was noted attendance by Board Members at MEC would not be compensable as the Board member is purely a guest. It was suggested the policy be revised to reflect that "attendance at meetings of the Tri-City Hospital Auxiliary and Tri-City Hospital Foundation at the request of the Chair of the Board shall be compensated, provided that the meeting is at least 30 minutes in length, the Director is physically present during the meeting for not less than 30 minutes and further provided that compensation is limited to fifty ($50) per meeting". Discussion was held regarding reimbursement for participation via teleconference. Mr. Moser stated no compensation is provided via teleconference from a location which is not a location open to the public per the Brown Act and within the jurisdiction. **It was moved by Dr. Ma to recommend approval of amendments to Board Policy 16-040 – Activities for Which Compensation is Available as described. Director Reno seconded the motion. The motion**	Recommendation to be sent to the Board of Directors to approve amendments to Board Policy 16-040 – Activities for Which Compensation is	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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	passed unanimously. It was recommended amendments to Board Policy 16-040 be placed on the New Business section of the February Board agenda rather than the Consent Agenda.	Available; item to be placed under New Business on Board agenda and included in agenda packet.	
g. Review and discussion of process for assuming office	Director Reno stated she placed discussion of process for assuming office on today's agenda as she believes there should be a formal standard process that is followed for new and re-elected Board members that are sworn in. Director Reno expressed her appreciation for General Counsel's memorandum that reflected the laws regarding the swearing in of public officials. Director Reno also commented that community members were disappointed in the lack of appetizers at the Swearing In Ceremony and physicians commented on the lack of a formal invitation to the swearing in. Mr. Moser explained the same rule applies to all government officials. The office holder is required to sign the oath of office and said oath must be witnessed and filed in the office of the clerk or secretary of the District. Mr. Moser's memorandum explained the various individuals who are qualified to administer the oath. There is no legal requirement with regards to a formal ceremony. Chairman Dagostino questioned if there is no legal requirement for a celebration ceremony is it an abuse of public funds to provide refreshments. Director Reno suggested Procopio's memorandum be followed in the future for administering the Oath of Office and the selection process for choosing an individual to administer the oath should be agreed upon by those being sworn in rather than the Board Chair. Mr. Moser commented that the swearing in process has been handled traditionally on an ad hoc basis and there have not been any issues in the past. It was recommended today's committee minutes be retained by the Executive Assistant for reference in	Procopio's memorandum of December 21, 2016 related to "Laws Regarding the Swearing in of Public Officials" will be retained along with today's committee minutes for reference in future election years.	Ms. Donnellan

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #15-013 (FOP)

POLICY TITLE: Policies and Procedures Including Bidding Regulations Governing Purchases of Supplies and Equipment, Procurement of Professional Services, and Bidding for Public Works Contracts

Government Code section 54202 requires the District to adopt policies and procedures, including bidding regulations, governing purchases of supplies and equipment by the District. In addition, with limited exceptions, Health & Safety Code section 32132 requires the District to competitively bid contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for materials and supplies to be furnished, sold, or leased to the District, as well as contracts involving expenditures of more than Twenty Five Thousand Dollars ($25,000) for work to be done. Finally, Government Code section 4525 et seq. requires the District to select firms to provide certain professional services on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required.

The following policies and procedures governing purchases of supplies and equipment, procurement and bidding for public works contracts, and procurement of professional services are hereby adopted.

I. FORMAL BIDDING REQUIREMENTS

A. Contracts Requiring Formal Bids – Materials, Supplies, and Work to be Done Involving Expenditure of More Than $25,000.

Unless exempted by this Policy or applicable law (including, for example, bidding exemptions for medical or surgical equipment or supplies and professional services), any contract for work to be done or for materials and supplies to be furnished, sold, or leased to the District shall be awarded through the "formal" bidding procedures specified in this Section "I" (Formal Bidding Requirements) if they involve an expenditure of more than Twenty Five Thousand Dollars ($25,000). (H&S Code § 32132(a).) Unless otherwise provided by law or this policy, such contracts involving an expenditure of Twenty Five Thousand Dollars ($25,000) or less may be made through the procedures specified in Section "II" or "III" of this policy. As used herein, "work to be done" includes, among other things, general maintenance work and public works contracts. Statutes requiring bidding, and exceptions from competitive procurement requirements for certain types of contracts are summarized in the table attached hereto and incorporated herein as Exhibit A for easy reference.

B. Bid Procedures.

1. Preparation of Bid Package.

Before entering into any contract which requires formal bidding, the District shall prepare or cause to be prepared a bid package. Unless exempted by the President/CEO or his/her designee pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, the bid package shall include a notice inviting bids, instructions to bidders, bid form, which shall include a provision as to the method for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," contractors qualification statement contract form, conditions of the contract, required bonds and other forms, drawings, and full, complete, and accurate plans and specifications, giving such directions as will enable any competent supplier or contractor to ascertain and carry out the contract requirements. The bid package shall also contain a statement that no gratuities of any kind will be accepted, including meals, gifts or trips, and violation of this condition may constitute immediate disqualification.

The President/CEO or his/her designee shall endeavor to include all required contract documents in the bid package. To the extent that the President/CEO or his/her designee determines, pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, that any required contract document cannot be incorporated into the bid package, its terms shall be negotiated with the lowest responsible bidder prior to the award of the contract.

To the extent possible, the plans and specifications shall also be reviewed and approved by the District's authorized representative prior to their insertion in the bid package.

2. Notice Inviting Bids – Contents.

All bid packages shall include a notice inviting bids. The notice inviting bids shall include, among other things determined necessary for a particular contract by the President/CEO or his/her designee, information as to the type, quality and quantity of materials, supplies or work to be provided, the contract performance schedule, the project location, the basis for determining the lowest bidder, whether on: 1. Base bid alone; 2. Identified alternates; 3. Prioritized order of alternates within identified budget; or 4. Other "fair manner," a contact person, and other bid requirements and information regarding how to obtain a bid package, the place where bids are to be received, and the time by which they are to be received. For contracts involving public works projects, the notice inviting bids shall also contain any other information required by state law or

Section "IV" (Provisions Applicable to Public Works Contracts) of this Policy.

3. Notice Inviting Bids - Distribution by Mail, Posting or Other Means.

The District shall distribute the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. The President/CEO, or his/her designee may require that, except in cases of emergency or where not practicable, all suppliers and contractors who have notified the District in writing that they desire to bid on contracts, and all suppliers and contractors which the District would like to bid on contracts, shall be furnished with the notice inviting bids by postal or electronic mail.

The President/CEO, or his/her designee, may also require that in addition to notifying all such persons by mail or electronic mail, the District shall post the notice inviting bids in one or more public places typically used by the District. It shall be posted in sufficient time in advance of the bid opening to allow bidders to bid, as determined by the President/CEO or his/her designee. The notice shall remain posted until an award has been made. Notice may also be made by internet, telephone, facsimile, telegram, personal contact, letter, or other informal means.

4. Notice Inviting Bids - Advertising/Publication.

The District shall advertise/publish the notice inviting bids by appropriate means as determined by the President/CEO or his/her designee in a manner to permit reasonable competition consistent with the nature and requirements of the proposed contract. For example, the President/CEO or his/her designee may require that, except in cases of emergency or where circumstances require that less notice be given, the notice inviting bids shall be published on the District's website and, in the case of a public works project also furnished to one or more contractor plan rooms or services.

For cost efficiency purposes, the published notice inviting bids need not be as detailed as that provided by other means, including by mail, posting or inclusion in the bid package, but should contain the legally and practically required essential contents of the notice, including but not limited to, where and how to obtain the complete bid package, Labor Code notice provisions, and bonding requirements.

5. Bid Form.

As part of the bid package, the District shall furnish to each bidder an appropriate bid form prepared by the District for the type of contract being let. Bids not presented on forms so furnished, or exact copies thereof,

shall be rejected as non-responsive. Bidders shall be required to execute and submit the contract in the form provided in the bid package as part of their bid.

6. Presentation of Bids.

All bids shall be presented under sealed cover. Upon receipt, the bid shall be date and time stamped.

7. Withdrawal of Bids.

Bids may be withdrawn at any time prior to the time fixed in the public notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of a bid does not prejudice the right of the bidder to timely file a new bid. Except as authorized by law for public works contracts (Pub. Contract Code § 5100 et seq.), no bidder may withdraw its bid after opening for the period of time indicated in the bid package.

C. Award of Contracts.

1. Opening of Bids.

On the day named in the public notice, the District shall publicly open the sealed bids.

The Board of Directors is under no obligation to accept the lowest responsive and responsible bid received, since the District has absolute discretion in the acceptance of bids and reserves the right to reject all bids if it is desires. The Board of Directors also reserves the right to determine the conditions of responsibility including matters such as delivery date, product quality, and the service and reliability of the supplier.

2. Responsible Bidder.

The District's determination of whether a bidder is responsible shall be based on an analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest bidder is to be rejected because of an adverse determination of the bidder's responsibility based on the District's staff review, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility. In such event, the District shall give the rejected bidder and the bidder to be awarded the contract at least five (5) working days' notice of a public board meeting at which the responsibility issue shall be considered by the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be required. The Board may, in its discretion, continue its

consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be conclusive.

3. Bid Challenges.

If any bidder wishes to challenge a potential bid award, he shall file a written objection within five (5) calendar days following bid opening. The written objection shall include specific reasons why the District should reject the bid questioned by the bidder. The District may, in its discretion, consider the protest during the public meeting at which the contract award is to be considered, or it may consider it at a prior meeting. The District shall give the challenging bidder and the bidder to be awarded the contract at least five (5) working days' notice of the board meeting at which the challenge shall be considered by the Board or the Appeals Panel. No other notice, other than that required for Agenda descriptions by the Ralph M. Brown Act, shall be required. The Board may, in its discretion, continue its consideration and determination of the issue to future meetings of the Board within the time authorized for the award of the contract. The Board's decision shall be final.

D. Emergencies.

The Board of Directors has adopted a resolution pursuant to Public Contract Code section 22050 authorizing the Chief Executive Officer (or the Chief Operating Officer if the Chief Executive Officer is unavailable, or a non-elected officer or employee of the District upon delegation of such authority by the Chief Executive Officer or Chief Operating Officer) to take immediate action and award certain emergency contracts not exceeding $250,000 (Two Hundred Fifty Thousand Dollars) without seeking competitive bids ("Emergency Contract Resolution"). The scope of such delegation and authority, including the process for such award and subsequent review by the Board of Directors, is set forth in the Emergency Contract Resolution. In the event that the Emergency Contract Resolution is rescinded, revoked, modified, amended, replaced, or superseded, this policy shall be read and interpreted consistent with the most recent action by the Board of Directors regarding authority to award emergency contracts even if this policy has not yet been amended to conform to such Board action. This is in addition to the District's authority under Health & Safety Code section 32136 as it may be amended from time to time.

II. GROUP PURCHASING ORGANIZATIONS ("GPO").

The District may participate as a member of any organization described in Section 23704 of the Revenue and Taxation Code ("GPO"). Any purchases made, or services rendered, by the GPO on behalf of the District are not subject to the bidding requirements pursuant to Section 32123 of the Health and Safety Code and are not subject to the formal bidding

requirements or informal competitive purchasing procedures established by this policy. (H&S Code § 32132(e).)

III. INFORMAL COMPETITIVE PURCHASING PROCEDURES

A. Contracts Requiring Informal Competitive Procurement Procedures.

All contracts subject to this Policy and not subject to Sections I or II shall be awarded in accordance with this Section III (Informal Competitive Purchasing Procedures).

B. Requirements for Specific Types of Contracts.

1. Certain Professional Services (Professional Architecture, Landscape Architectural, Engineering, Environmental, Land Surveying, Construction Management).

Contracts for professional services, as defined in Government Code section 4526, as it may be amended from time to time, may be awarded without following the "formal" bidding procedures, but shall meet the "informal" competitive purchasing procedures specified in Section III" (Informal Competitive Purchasing Procedures) of this Policy or comply with Board Policy No. 14-023. (Gov. Code § 4525 et seq.) In no event shall a contract for professional services be awarded based solely upon the lowest cost to the District.

a. Proposals Submitted for Construction Project Management Services

Any individual or firm proposing to provide construction project management services shall provide evidence that the individual or firm and its personnel carrying out onsite responsibilities have expertise and experience in construction project design review and evaluation, construction mobilization and supervision, bid evaluation, project scheduling, cost-benefit analysis, claims review and negotiation, and general management and administration of a construction project. (Gov. Code § 4529.5.)

b. Maximum Participation of Small Business Firms

In selecting professional services of private architectural, landscape architectural, engineering, environmental, land surveying, or construction management firms, the selection procedures shall assure maximum participation of small business firms, as defined by the Director of General Services pursuant to Section 14837. (Gov. Code § 4526.)

2. Electronic Data Processing and Telecommunications Goods and Services.

Contracts for electronic data processing and telecommunications goods and services shall be awarded through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures of this Policy); provided, that such contracts may be made without soliciting or securing bids when they involve an expenditure of $25,000 or less or when the Board determines either that: (1) the goods and services proposed for acquisition are the only goods and services which can meet the District's need; or (2) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare, or safety.

3. Professional Financial, Economic, Accounting, Legal or Administrative Services.

Contracts for the professional services set forth in Government Code section 53060, which include but are not limited to special services and advice in financial, economic, accounting, legal or administrative professional services may be procured through the "informal" competitive purchasing procedures specified in Section "III" (Informal Competitive Purchasing Procedures) of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the Board, or the President/CEO.

4. Clinical Services Agreements.

All clinical services agreements (e.g., anesthesiology, pathology, radiology, emergency, hospitalists) shall be subject to competitive selection procedures based on recommendations from General Counsel and/or outside special healthcare counsel. Such contracts may be procured through the Informal Competitive Purchasing Procedures of this Policy or in any other manner as deemed to be in the best interest of the District as determined by the President/CEO.

C. Informal Competitive Purchasing Procedures.

1. Contracts Exceeding $1,000,000.

a. The President/CEO or his/her designee will issue a formal Request for Proposal for any individual contract award (not required to be bid by statute) exceeding One Million Dollars ($1,000,000) unless a written sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

b. Preparation of Request for Proposals.

The President/CEO or his/her designee shall prepare or cause to be prepared a written request for proposals ("RFP"). Unless exempted by the President/CEO or his/her designee pursuant to Section "V" (Flexibility and Waiver of Policy Requirements) below, the RFP shall include at least the following information: (1) the specific nature or scope of the goods and/or services being sought; (2) the type of project contemplated, if applicable; (3) the estimated term of the contract; (4) the specific experience expected of the consultant or supplier; (5) the time, date and place for submission of the RFP; (6) a contact person who can answer questions of the consultants or supplier during the bidding process; (7) a contract form; and (8) the evaluation criteria to be utilized in the selection of the consultant or supplier.

The President/CEO or his/her designee shall endeavor to include all required information in the RFP. To the extent that the President/CEO or his/her designee determines, pursuant to Section "VI" (Flexibility and Waiver of Policy Requirements) below, that any required information cannot be incorporated into the RFP, its terms shall be negotiated with the successful consultant or supplier prior to the award of the contract.

c. Circulation of Request for Proposals.

The District shall attempt to obtain and consider completed RFP's from at least three (3) qualified sources.

2. Contracts Greater than or Equal to $250,000 and Less Than or Equal to $1,000,000.

The President/CEO or his/her designee shall obtain at least three (3) quotes from vendors for any proposed individual contract award (not otherwise required by statute to be bid) between Two Hundred Fifty Thousand Dollars ($250,000) and One Million Dollars ($1,000,000), unless a written sole source justification is provided to and approved by the President/CEO. The approved sole source justification will be provided to the Board of Directors and Board committee as part of the contract approval process.

3. Contracts Less Than $250,000.

a. Unless otherwise required by applicable law or this Policy, contracts less than Two Hundred Fifty Thousand Dollars ($250,000) may be awarded without soliciting bids or proposals from multiple vendors. Agreements for legal services shall be

approved by the Board or its designee pursuant to Board Policy No. 14-023.

b. Contracts for electronic data processing and telecommunications goods and services with a cost to the District of more than Twenty-Five Thousand Dollars ($25,000) and less than Two Hundred Fifty Thousand Dollars ($250,000) shall be awarded after obtaining quotes from a minimum of three (3) vendors. Contracts with a cost of Two Hundred Fifty Thousand Dollars ($250,000) or more shall be subject to the procedures stated in Section III.C. (Informal Competitive Purchasing Procedures), subsections 2 and 3, as applicable.

D. Award of Contracts.

1. Electronic Data Processing and Telecommunications Goods or Services Exceeding $25,000.

When the District awards a contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures) for electronic data processing and telecommunications goods or services with a cost to the District of more than Twenty Five Thousand Dollars ($25,000), the contract award shall be based on the proposal which provides the most cost effective solution to the District's requirements, as determined by the specified evaluation criteria. The evaluation criteria may provide for the selection of a consultant or supplier on an objective basis other than cost alone (H&S Code § 32138(c).)

2. Other Contracts.

When the District awards any other contract pursuant to this Section "III" (Informal Competitive Purchasing Procedures), the contract award shall be based on the proposal which is in the best interests of the District. In addition, unless exempted pursuant to Government Code section 4529, contracts for professional architectural, landscape architectural, engineering, environmental, land surveying, construction management and any other services specified in Government Code section 4526, as it may be amended from time to time, shall be awarded on the basis of demonstrated competence and on the professional qualifications necessary for the satisfactory performance of the services required. In no event shall a contract for such professional services be awarded on the basis of cost alone. (Gov. Code § 4525 et seq.)

IV. PROVISIONS APPLICABLE TO PUBLIC WORKS CONTRACTS

A. Prequalification May Be Required Prior to Bidding on Public Works Contracts.

On a case-by-case basis based on the complexity and estimated cost of a contract, as determined by the President/CEO or his designee, the District may require all prospective bidders, including not only contractors also subcontractors, to prequalify by fully completing a pre-qualification questionnaire available from the District, providing a current Dunn & Bradstreet report and bond rating, and providing all materials requested by the District's Notice of Prequalification of Bidders, and be approved by the District to be on the final Bidders list. A financial statement shall not be required from a prospective bidder who has qualified as a Small Business Administration entity pursuant to paragraph (1) of subdivision (d) of Section 14837 of the Government Code, when the bid is no more than twenty-five percent (25%) of the qualifying amount provided in paragraph (1) of subdivision (d) of Section 14837 of the Government Code.

If prequalification is required by the District, no bid will be accepted from a bidder that has failed to comply with these requirements. If two or more business entities submit a bid on a project as a Joint Venture, or expect to submit a bid as part of a Joint Venture, each entity within the Joint Venture must be separately qualified to bid.

The President/CEO, or his designee, shall adopt and apply, on behalf of the District, a uniform system of rating bidders on the basis of the completed questionnaires and financial statements, in order to determine both the minimum requirements permitted for qualification to bid, and the type and size of the contracts upon which each prospective bidder shall be deemed qualified to bid. The uniform system of rating prospective bidders shall be based on objective criteria.

The District will use the information and documents submitted by prospective bidders as the basis of rating prospective bidders in respect to the size and scope of contracts upon which each prospective bidder is qualified to bid. The District reserves the right to check other sources available.

The prospective bidder's inclusion on the final Bidder's list does not preclude the District from a post-bid consideration and determination on a specific project of whether a bidder has the quality, fitness, capacity and experience to satisfactorily perform the proposed work, and has demonstrated the requisite trustworthiness.

The pre-qualification packages should be submitted under seal and marked "CONFIDENTIAL" to Tri-City Healthcare District Facilities Department by the date and time specified in the quarterly Notice of Prequalification issued by the District.

The pre-qualification packages submitted by prospective bidders are not public records and are not open to public inspection. All information provided will be

kept confidential to the extent permitted by law, although the contents may be disclosed to third parties for the purpose of verification, investigation of substantial allegations, and in the process of an appeal hearing. State law requires that the names of contractors applying for pre-qualification status shall be public records subject to disclosure, and the first page of the questionnaire will be used for that purpose.

Each questionnaire must be signed under penalty of perjury in the manner designated at the end of the form, by an individual who has the legal authority to bind the prospective bidder on whose behalf that person is signing. If any information provided by a prospective bidder becomes inaccurate, the prospective bidder must immediately notify the District and provide updated accurate information in writing, under penalty of perjury.

The District reserves the right to waive minor irregularities and omissions in the information contained in the pre-qualification application submitted, to make all final determinations, and to determine at any time that the pre-qualification procedures will not be applied to a future public works project. The District shall notify each prospective bidder submitting an application for prequalification in writing by first-class mail or email within ten (10) days after the District's decision as to prequalification. Upon request of the prospective bidder, the District shall provide notification to the prospective bidder in writing of the basis for the prospective bidder's disqualification and any supporting evidence that has been received from others or adduced as a result of an investigation by the District.

After receiving notice of the basis for disqualification, the prospective bidder (except where disqualified for failure to submit required information) may file a written protest to the disqualification within seventy-two (72) hours of its receipt of notice of disqualification. Receipt shall be deemed to be two (2) days after mailing of the notice. The written objection shall include specific reasons, facts, supporting documentation and legal authorities explaining why the prospective bidder should be found qualified.. The written objection must be filed with:

Tri-City Healthcare District
Facilities Department
4002 Vista Way
Oceanside, CA 92056

Unless a prospective bidder files a timely appeal, the prospective bidder waives any and all rights to challenge the prequalification decision of the District, whether by administrative process, judicial process or any other legal process or proceeding.

If the prospective bidder gives the required notice of appeal and requests a hearing, the hearing shall be conducted no later than ten (10) business days after the District's receipt of its Notice of Appeal. The hearing so provided shall be

conducted by a panel to which the District's Board of Directors has delegated responsibility to hear such appeals (the "Appeals Panel"). At the hearing, the prospective bidder will be given the opportunity to present information and present reasons in opposition to the pre-qualification determination. At the conclusion of the hearing or no later than three (3) business days after completion of the hearing, the Appeals Panel will render its decision.

Prospective bidders shall be allowed to dispute their proposed prequalification rating prior to the closing time for receipt of bids. In the event that the District circulates bid packages before the completion of a pending appeal, the District will provide the prospective bidder with a bid package only after the prospective bidder has made payment therefore in an amount equal to the District's cost of printing and reproduction of the bid package, if any. The District will reimburse the prospective bidder for such amount if the prospective bidder successfully appeals the disqualification determination and is found to be qualified to submit a bid. The Appeals Panel shall render its decision on the pending appeal prior the closing time for receipt of bids.

B. Bid Security.

All bids shall be accompanied by bid security in an amount equal to at least ten percent (10%) of the total bid price. The security shall be in a form as follows:

1. Cashier's or Certified Check in the required amount; or

2. Bidder's Bond executed by an admitted surety insurer and made payable to the District.

Any bid not accompanied by one of the foregoing forms of bidder's security shall be rejected as non-responsive.

C. License and Registration Requirement.

The notice inviting bids and plans shall identify the required contractor's license classification. (Pub. Cont. Code § 3300.) In every completed bid, and in all construction contracts and subcontracts, shall be included the license number of the contractor and all subcontractors working under him. No project may be awarded to a contractor which is not licensed pursuant to state law or which utilizes subcontractors not so licensed.

Additionally, all contractors and subcontractors listed on a bid proposal for a public works project must be registered with the California Department of Industrial Relations ("DIR") pursuant to Labor Code section 1725.5 (with limited exceptions from this requirement for bid purposes only under Labor Code section 1771.1(a)). No contractor or subcontractor may be awarded a contract for public work on a public works project unless registered with the DIR.

D. Insurance.

All contracts shall require insurance of the type, in amounts and with provisions approved by District Legal Counsel. All contractors awarded contracts shall furnish the District with original certificates of insurance and endorsements effecting coverage required by the contract. The certificates and endorsements for each insurance policy shall be signed by a person authorized by that insurer to bind coverage on its behalf, and shall be on forms supplied or approved by the District. All certificates and endorsements must be received and approved by the District before work commences, or sooner if indicated by the contract documents. The District shall reserve the right to require complete, certified copies of all required insurance policies, at any time.

At a minimum, all general liability and automobile insurance policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (1) the District, its directors, officers, employees and agents shall be covered as additional insureds with respect to the work or operations performed by or on behalf of the contractor, including materials, parts or equipment furnished in connection with such work; and (2) the insurance coverage shall be primary insurance as respects the District, its directors, officers, employees and agents, or if excess, shall stand in an unbroken chain of coverage excess of the contractor's scheduled underlying coverage. Any insurance or self-insurance maintained by the District, its directors, officers, employees and agents shall be excess of the contractor's insurance and shall not be called upon to contribute with it in any way.

At a minimum, all workers' compensation and employers' liability policies shall contain the following provision, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provision to the insurance policies: (1) the insurer shall agree to waive all rights of subrogation against the District, its directors, officers, employees and agents for losses paid under the terms of the insurance policy which arise from work performed by the contractor.

At a minimum, all policies shall contain the following provisions, or contractor shall provide endorsements on forms supplied or approved by the District to add the following provisions to the insurance policies: (l) coverage shall not be canceled except after thirty (30) days prior written notice by mail has been given to the District; and (2) any failure to comply with reporting or other provisions of the policies, including breaches of warranties, shall not affect coverage provided to the District, its directors, officials, officers, employees and agents. Insurance carriers shall be qualified to do business in California and maintain an agent for process within the state. Such insurance carrier shall have not less than an "A" policyholder's rating and a financial rating of not less than "Class VII" according to the latest Best Key Rating Guide.

All insurance required by the contract shall contain standard separation of insureds provisions. In addition, such insurance shall not contain any special limitations on the scope of protection afforded to the District, its directors, officers, employees or agents.

All builders'/all risk insurance policies shall provide that the District be named as loss payee. In addition, the insurer shall waive all rights of subrogation against the District. The making of progress payments to the contractor shall not be construed as creating and insurable interest by or for the District, or as relieving the contractor or its subcontractors of any responsibility for loss from any direct physical loss, damage or destruction covered by the builders'/all risk policy occurring prior to final acceptance of the work by the District.

The District shall not be liable for loss or damage to any tools, machinery, equipment, materials or supplies of the contractor. The contractor shall supply to the District an endorsement waiving the insurance carrier's right of subrogation against the District for all policies insuring such tools, machinery, equipment, materials or supplies.

E. Contract Terms.

All contract terms, including, but not limited to, the contract form, general conditions and special conditions, shall include any applicable mandatory public works provisions and shall be approved by District Legal Counsel.

F. Changes in Plans and Specifications.

Every contract shall provide that the District may make changes in the plans and specifications for the project after execution of the contract. Bid procedures as set forth in this Policy need not be secured for change orders which do not materially change the scope of the project, as set forth in the original contract, if the contract was made after compliance with bidding requirements, and if each individual's change order does not total more than five percent (5%) of the original contract. (H&S Code § 32132(c).)

All changes or amendments to the original contract must be in writing and signed by both the contractor and a duly authorized representative of the District.

V. AUTHORITY TO AWARD CONTRACTS

The President/CEO may award contracts within his/her signatory authority as provided in the Approval and Authorization Matrix, and consistent with Board Policy No. 14-023 and this Policy, unless Board of Directors approval is required by law. All contracts exceeding the President/CEO's signature authority shall be awarded by the Board of Directors only.

VI. FLEXIBILITY AND WAIVER OF POLICY REQUIREMENTS

In recognition of the fact that the contracting and procurement needs of the District may from time to time render certain procedures or requirements herein impracticable, the President/CEO or his/her designee is authorized to permit or waive deviations from this Policy, to the extent permitted by law, upon making a written finding that such deviations are in the District's best interests in consultation with District Legal Counsel as to legal issues involved.

Additionally, provisions required by Section "IV" (Provisions Applicable to Public Works Contracts) to be included in public contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts, if appropriate.

VII. CONFLICTS OF INTEREST

As to all contracts covered by this policy, any practices which might result in unlawful activity including, but not limited to, rebates, kickbacks, or other unlawful consideration, are prohibited. No employee may participate in the selection process when the employee has a relationship with a person or business entity seeking a contract when disqualified under the provisions of Section 87100 of the Government Code or other provisions of law. (See, Gov. Code § 4526.) Additionally, all employees must comply with the District's Code of Conduct, including restrictions on accepting gifts and entertainment.

Reviewed by the FO&P Committee: 11/21/06
Approved by the Board of Directors: 12/14/06
Reviewed by the FO&P Committee: 11/27/07
Approved by the Board of Directors: 12/13/07
Reviewed by the FO&P Committee: 11/16/10
Approved by the Board of Directors: 12/16/10
Approved by the FO&P Committee: 6/18/14
Approved by the Board of Directors: 6/26/14
Reviewed by the FO&P Committee: 8/18/15
Approved by the Board of Directors: 8/27/15

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
January 11, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 1/27/2017-12/31/2018)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 1/27/2017 through 12/31/2018:

- **BAHARI, Abbas M.D. / Neurosurgery (Covering for Dr. Yoo)**
- **GERBER, Michele M.D. / OB/GYN (ScrippsHealth)**
- **HOOPES, David MD/Radiation Oncology (UCSD)**
- **KATO, Kambrie M.D. / Diagnostic Radiology (StatRad)**
- **KERNS, Garrett M.D. / Orthopedic Surgery (San Diego Sports Medicine)**
- **KORABATHINA, Kalyani MD / Neurology (North County Neurology Assoc.)**
- **MCQUEEN, Peter M.D. / Orthopedic Surgery (San Diego Sports Medicine)**
- **PRINCE, Jennifer D.O. / Pediatrics (Vista Community Clinic)**
- **RICHTAND, Neil M.D., PhD / Psychiatry (UCSD)**
- **SINGH, Himani M.D. / Oncology (North County Oncology)**
- **WATSON, Jeffrey M.D. / Otolaryngology (Moradi MD)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
January 11, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 02/01/2017 -1/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 02/01/2017 through 1/31/19, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- BERDJIS, Farhouch MD/Pediatric Cardiology/Consulting
- BORGSCHULTE, Gitte MD/Internal Medicine/Provisional
- EPNER, Steven MD/Radiology/Active
- HOSALKAR, Harish MD/Orthopedic Surgery/Active
- KRAK, Michael MD/Pediatrics/Active
- MAEDA, Andrew MD/Anesthesiology/Provisional
- MAZAREI, Rahele DO/OB/GYN/Active
- MILLER, Nathan MD/Pain Medicine/Active
- MONGEON, Robert MD/Internal Medicine/Active
- SCHER, Colin MD/Ophthalmology/Provisional
- SCHWEIKERT, Suzanne MD/OB/GYN/Consulting
- SHIH, Robert MD/Anesthesiology/Courtesy
- SHIMIZU, Kenneth MD/Radiation Oncology/Active
- TAYLOR, Tasha MD/Pediatrics/Active
- THOMAS, David MD/Dermatology/Affiliate

RESIGNATIONS: (Effective date 1/31/2017 unless otherwise noted)

Voluntary:

- ANTHONY, Julian N. MD/Urology

Attachment B

- COOPER, Edward MD/Emergency Medicine
- DERTINA, Damon, M., MD/Anesthesiology
- GE, Xupeng, MD/Anesthesiology
- GIL, Orna MD/OB/GYN
- LOVIN, Jeffrey MD/Radiology
- MAGULAC, Mark L., MD/Psychiatry
- MELLGREN, Sally MD/Ophthalmology
- MITRUKA, Surindra MD/Cardiothoracic Surgery
- MUTH, Natalie MD/Pediatrics
- NUCKOLS, Matthew, MD/Anesthesiology
- RANSOM, Mark S., MD/Anesthesiology
- TOM, Clifford C., MD/Anesthesiology
- VARGAS, Michael MD/Cardiology
- ZANE, Gary, MD/Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
January 11, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS

PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 1/31/2017.

- AMINLARI, Amy M.D. — Emergency Medicine
- GOLD, Evan S., DMD — Oral & Maxillofacial Surgery
- GOLDSZTEIN, Hernan, M.D. — Otolaryngology
- HAJNIK, Christopher A., M.D. — Orthopedic Surgery
- KELLY, Jon P., MD — Orthopedic Surgery
- MATTHEWS, Oscar A., MD — Cardiology
- PHILLIPS, Jason M., MD — Urology
- WANG, Chunyang, T., MD — Neurology

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 1/27/2017, unless otherwise specified)

The following practitioners are voluntarily relinquishing the following privileges.

- CHOUDRY, Bilal A., MD — Neurology
- DHILLON-ASHLEY, Tina, MD — OB/GYN
- JESWANI, Sunil P., MD — Neurological Surgery
- TABIBZADEH, Sepehr, MD — Anesthesiology
- VIETS, Ryan B., MD — Neuroradiology Surgery
- WILLIAMS, Kristin, MD — Maternal & Fetal Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
January 11, 2017

Attachment B

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by July 31, 2017 would result in these privileges automatically relinquishing.

- EL-SHERIEF, Karim H., MD — Cardiology
- KAYAL, Anas, MD — Nephrology
- TUNG, Howard, MD — Neurological Surgery

STAFF STATUS CHANGES

- LESHAW, Steven MD
- PARK, Gregory MD
- RICHMOND, Howard MD
- VIETS, Ryan MD

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
January 11, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 1/27/17, unless otherwise specified)

• BOONJINDASUP, Aaron M.D.	Urology
• DHILLON-ASHLEY, Tina M.D.	OB/GYN
• EIKERMANN, Eric S., MD	Anesthesiology
• SCHOENFELD, William MD	Anesthesiology
• SEIDEN, Grant M.D.	Orthopedic Surgery
• SMITH, Christina MD	Anesthesiology
• ZHU, Shiyin MD	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
January 19, 2017

Attachment A

INITIAL APPOINTMENT TO THE ALLIED HEALTH PROFESSIONAL STAFF

Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following AHPs have met the basic requirements of staff and are therefore recommended for appointment effective 1/27/2017 through 12/31/2018:

- **BALLANTINE, Katherine CNM/Allied Health Professional**
- **NAVARO, Katherine PAC/Allied Health Professional**
- **SAKHAROV, Aleksandr PA/Allied Health Professional**
- **SCOTT, Katie PAC/Allied Health Professional**
- **SILVERWOOD, Cristie NP/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
January 19, 2017

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 2/1/2017 – 1/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 2/1/2017 through 1/31/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- AHUMADA, Alejandro, AuD/Allied Health Professional
- ALSTON, Vickie, CNM/Allied Health Professional
- BUCKLEY, Alicia, Ortho Tech/Allied Health Professional
- CHASE, Nicole PAC/Allied Health Professional
- HAMMONDS, Tommy PAC/Allied Health Professional
- JAMARILLO, Elizabeth, (aka: AMARAL, Polly) AuD/Allied Health Professional
- KARVER-CHRISTENSON, Elyse CNM/Allied Health Professional
- KING, John, AuD/Allied Health Professional
- MATEO, Marie CNM/Allied Health Professional
- LEES, Shannon, AuD/Allied Health Professional
- OLSON, Lindsey, PAC/Allied Health Professional
- SCHROEDER, Mary, CNM/Allied Health Professional
- SON, Alicia, PAC/Allied Health Professional

RESIGNATIONS: (Effective date 1/27/2016 unless otherwise noted)

- GENDELMAN, Jordan MFT/Allied Health Professional
- GOODWIN, Rachel CNM/Allied Health Professional
- HELDT, Emily AuD/Allied Health Professional
- NUNEZ, Blanca PA-C/Allied Health Professional

Attachment B

- PIDDING, Apryl NP/Allied Health Professional
- STEWART-GARBRECHT, Eleanor, CNM/Allied Health Professional
- STROWD, Megan PA-C/Allied Health Professional
- TUANQUIN, Tina AuD/Allied Health Professional
- WOELKE, Dianne CNM/Allied Health Professional

Tri-City Medical Center

Delineation of Privileges

Neurosurgery - 12/16

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: The Division of Neurosurgery consists of physicians who are Board Certified or are actively pursuing certification by the American Board of Neurological Surgery (effective retroactive to 2000), or be able to demonstrate comparable ability, training and experience.

Division of Neurosurgery members are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of Internal Medicine although not necessarily at the level of a sub-specialist. Such physicians may act as consultants to others and may, in turn, be expected to request consultation when:
a. Diagnosis and/or management remain in doubt over an unduly long period of time, especially in the presence of a life threatening illness;
b. Unexpected complications arise which are outside this level of competence;
c. Specialized treatment or procedures are contemplated with which they are not familiar.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056.

Please mark through and initial any privileges that you do not wish to include in your privilege bundles.

COGNITIVE PRIVILEGES

___ Admit patients ___

___ Consultation, including via telemedicine (F) ___

___ History and physical examination, including via telemedicine (F) ___

GENERAL NEUROSURGERY PROCEDURES
Initial Criteria:
1. Successful completion of an ACGME- or AOA-accredited residency in neurological surgery.
2. Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.

Proctoring Requirement:
Six (6) cases, at least three (3) cases must be proctored for each of the two (2) categories of privileges granted (cranial/ skull based spine).

Reappointment Criteria:
All General Neurosurgery Privileges: Fifty (50) cases reflective of the privileges requested

___ **CRANIAL/SKULL BASE CATEGORY:** ___

- Ablative surgery for epilepsy
- All types of craniotomies, craniectomies, and reconstructive procedures (including microscopic) on the skull, including surgery on the brain, meninges, pituitary gland, and cranial nerves and including surgery for cranial trauma and intracranial vascular lesions
- Arteriography and angiography and complex interventional cases
- Management of congenital anomalies, such as encephalocele, meningocele, and myelomeningocele
- Shunts (VP, ventriculoatrial, ventriculopleural, subdural peritoneal, and lumbar subarachnoid/peritoneal [or other cavity])
- Tracheostomy
- Transsphenoidal procedures for lesions of the sellar or parasellar region, fluid leak, or fracture
- Ventricular shunt operation for hydrocephalus, revision of shunt operation, and ventriculocisternostomy
- Ventriculography

___ **SPINE CATEGORY:** ___

- Correction costoclavicular Compression and related procedures
- Discography and intradiscal/percutaneous disc treatments

Provider Name:

Request	Privilege	Action MSO Use Only

- Epidural steroid injections for pain
- Implantables (intrathecal or epidural infusion pumps with tunneled catheter, spinal cord stimulator)
- Insertion of subarachnoid or epidural catheter with reservoir or pump for drug infusion or cerebrospinal fluid withdrawal
- Intradiscal electrothermal annuloplasty
- Laminectomies, laminotomies, and fixation and reconstructive procedures of the spine and its contents, including instrumentation
- Lumbar puncture, cisternal puncture, ventricular tap, and subdural tap
- Myelography
- Nucleoplasty
- Percutaneous and subcutaneous implantation of neurostimulator electrodes
- Posterior fossa-microvascular decompression procedures
- Radiofrequency thermocoagulation ablation (RFTC)
- Sacral fusion
- Spinal cord surgery for decompression of spinal cord or spinal canal, for intramedullary lesion, intradural extramedullary lesion, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord, or other congenital anomalies (e.g., diastematomyelia)
- Surgery for intervertebral disc disease
- Vertebral Augmentation (Refer to Policy 8710-534)

___ **NERVOUS SYSTEM CATEGORY:** ___

- Autonomic Nervous Systems Surgery
- Biopsy: nerve, muscle
- Cranial nerve blocks – all types
- Peripheral nerve procedures, including temporary and permanent blocks, decompressive procedures, and reconstructive procedures on the peripheral nerves
- Selective blocks for pain, chemo-denervation, stellate ganglion blocks, intra-muscular phenol injections, and nerve blocks
- Sympathetic nervous system

___ **Vagal Nerve Stimulator**

Supplemental Requirements:

a) General Neurosurgery privileges

b) Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months or successful completion of vagal nerve stimulator therapy systew:\1 - reference documentation\privilege cards\working folder\neurosurgery privilege form.vagal nerve stimulator.docxm training program.

Proctoring: (2) cases need to be proctored

Reappointment: Documented completion of five (5) cases within the previ9ous twenty-four months.

MAZOR ROBOTIC SURGERY:

___ Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566 ___

___ Assist in Mazor robotic surgery - Refer to Credentialing Policy, Mazor Robotic Surgery #8710-566 ___

Moderate Sedation

Supplemental Requirements: (Refer to Policy 8710-517)

a) Completion of current Moderate Sedation Policy and the Moderate Sedation Self-Study Guide.

b) Successful passing grade (at least 80%) of the Moderate Sedation Post-Completion Test.

Provider Name:

Request	Privilege	Action MSO Use Only

Proctoring: (2) cases need to be proctored

Reappointment: Documented completion of three (3) cases of procedural sedation to meet reappointment criteria.

___ **Fluoroscopy** ___
in accordance with hospital policy (Refer to Medical Staff Policy 8710-528 and 8710-528A)

___ **Argon Laser** ___

Initial: Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.

Proctoring: One (1) case for each energy source

Reappointment: Two (2) cases

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____
Division/Department Signature

_____
Date

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
JANUARY 19, 2017

MEMBERS PRESENT: CHAC Chair Julie Nygaard, BOD Chair Jim Dagostino, Dr. Victor Souza, MD; Laura Vines (representing Barbara Perez), Bret Schanzenbach, Carol Herrera, Gigi Gleason, Guy Roney, Linda Ledesma, Marge Coon, Marilou de la Rosa Hruby, Mary Lou Clift, Mary Murphy, Rosemary Eshelman, Scott Ashton

MEMBERS ABSENT: Director Larry Schallock, Dung M. Ngo, Jack Nelson, Mary Donovan, Roma Ferriter, Ted Owen, Sandy Tucker, Xiomara Arroyo, Fernando Sanudo

NON-VOTING MEMBERS PRESENT: David Bennett, Chief Marketing Officer; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO; Audrey Lopez

NON-VOTING MEMBERS ABSENT: Steve Dietlin, CEO; Fernando Sanudo

OTHERS PRESENT: Robin Iveson, Gwen Sanders, Brian Greenwald, Celia Garcia, CHAC Coordinator; Susan McDowell, CHAC Coordinator

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The January 19, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:30 pm by Director and CHAC Chair Julie Nygaard.		
Approval Of Meeting Agenda	Bret Schanzenbach motioned to approve the January 19, 2017 meeting agenda. The motion was seconded by Director Dagostino and unanimously approved.		

Tri-City Medical Center
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Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

JANUARY 19, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Comments & Announcements	No public comments or announcements were made.		
Ratification Of Minutes	Director Dagostino motioned to approve the November 17, 2016 CHAC meeting minutes. The motion was seconded by Gigi Gleason and unanimously approved. (Note: No meeting in Dec 2016).		
Presentation: Susan Webster Medical Integration Program Manager Tri-City Wellness Center	Susan Webster addressed the group regarding her newly established Medical Integration Program position at the Tri-City Wellness Center. Susan noted that this program will be adapted from the original Pacific Cancer Fitness program that has been located at TCWC for several years now. Susan shared the following information about Cancer Fitness and what she wants to bring to the program: 1. The importance of exercise to reduce the risk of developing cancer and reducing the risk of a cancer recurrence. 2. The improvement of quality of life for both cancer patients and survivors. 3. Review of the American Cancer Society recommendations for physical activity. 4. The hazards of a sedentary lifestyle which promotes insulin resistance and inflammation increasing the risk for cancer and other chronic conditions. 5. The importance of exercise during cancer treatment to reduce fatigue, improve physical function, reduce loss of bone density, improve muscle mass and cardiovascular performance. 6. The importance of making exercise fun.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Medical Integration Program Manager Tri-City Wellness Center (con't)	Susan introduced Marta, a member of Pacific Cancer Fitness, who shared her very inspiring story about her cancer journey and how the cancer fitness program helped her regain her life and physical abilities back during and after treatment. Susan noted that the program provides weekly, supervised group training exercises, plus group fitness classes, for $60.00 per month for non-members and $35.00 per month for TCWC members.		
Committee Term Expirations & Renewals	The following committee positions were accepted / approved: a. District Resident O'side – Rev. Carol Brooks Rev. Carol Brooks will not be renewing her term. Position open. b. District Resident C'bad – Linda Ledesma Linda Ledesma – renewed term until January 2019 c. District Resident Vista – Currently Vacant Position open d. Multicultural - Xiomara Arroyo Xiomara Arroyo – renewed term until January 2019 e. Multicultural - Marilou de la Rosa Hruby Marilou de la Rosa Hruby – renewed term until January 2019 f. Oceanside School District Representative Barbara Perez - renewed term until January 2019		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Term Expirations & Renewals (Con't)	g. Oceanside Police/Fire – Vacant Position open		
Committee Communications	Chair Julie Nygaard noted that from time-to-time members of the CHAC committee would like information distributed to other CHAC members. Julie requested input from the members and no objections were raised to this type of member-to-member communication.		
Ethics Compliance Workshop	Information was provided to the members of the Committee noting the upcoming Ethics & Compliance Training required of all members of Board Committees. A flyer with detailed information was passed out to those in attendance. This information was also sent electronically to all members of the CHAC committee.		
CEO Update Steve Dietlin	N/A		
COO Update Kapua Conley	COO Kapua Conley updated the group noting the following: • TCMC is in the final stretch of completing the HUD approval and it is anticipated that completion will take place within the next 2 months. • The "Hospitality Lounge" will be opening next week. Kapua noted that this pilot program is unique in the hospital setting. The program will provide rides to discharged patients after their hospital stay. The program will incorporate general and medical transportation services depending on the need of the patient, and		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Kapua Conley (con't)	will also function as an extra set of eyes to determine if the patient needs Home Health or other types of assistance once they arrive home. If successful, this program may be expanded to accommodate ER patients. • Kapua shared the current hospital-wide Throughput Program noting the aim is to improve patient flow efficiency from ED arrival to departure or admission. • The final phase of paint striping on Vista Way is awaiting better weather. • Renovation projects are in a holding pattern at this time awaiting the completion of the HUD loan. • Kapua gave his thanks to those who attended the successful Carlsbad Marathon.		
Chief Marketing Officer Update David Bennett	Chief Marketing Officer David Bennett reported as follows: • David noted that the recent Carlsbad Marathon was a great success with over 8,000 runners from multiple countries, 23,000 spectators, 4 TV stations, 8 on-air interviews, and 104 + TCMC volunteers. • TCMC's recent partnership with the American Heart Association		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Chief Marketing Officer Update David Bennett (Con't)	will be sponsoring the first walk of this partnership in September. It is expected that 10,000+ participants and organizations will participate in this walk. • Marketing is currently working on new commercials and Physician lectures. • David provided information about TCMC's presence in the San Diego Business Journal's 2017 Book of Lists, including an article on the TCMC Board of Directors. • David noted that CEO Steve Dietlin was recognized in San Diego 500 magazine as one of the most influential leaders in San Diego County. • TCMC will be working with the San Diego Food Bank to support the dispersing of food to needy district residents from children to the elderly. • David presented the Cardiovascular Health Institute's 2 for 1 offer for the month of February in honor of Heart Health Month.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
JANUARY 19, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Public Comments	No public comments.		
Committee Communications	Chair Julie Nygaard welcomed O'side Chamber CEO, Scott Ashton, to the committee. Marilou de la Rosa Hruby noted that the Soroptimist Salad Luncheon is coming up and encouraged committee members to participate. Audrey Lopez noted that the North County Regional Center is moving to a Kaiser building during construction. Rosemary Eshelman relayed information about the Great Kindness Challenge. Information will be sent to the members of the group electronically. Gigi Gleason noted that the 2017 CHAC Grant Application is now on line for review. The TCMC website updated a banner on their opening page to make it easier to find the grant section. Carol Herrera expressed her thanks and appreciation to the TCMC Marketing Department for the good community sentiments and comments she receives about the hospital. Gwen Sanders thanked TCMC and the Marketing Department for their ongoing support of the NAACP and their recent Dr. Martin Luther King event. Scott Ashton noted the Oceanside "Meet the City" event to be held on		

Tri-City Medical Center
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TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Committee Communications (con't)	January 26th, and the upcoming Enlisted Reception at Camp Pendleton. Director Dagostino presented info to the group concerning a proposed project to feed district school children through a program developed and monitored through the CHAC committee. The group agreed to research other programs currently in operation for comparison purposes.		
Next Meeting	The next CHAC meeting is scheduled for Thursday, February 16, 2017.		
Adjournment	The January 2017 CHAC Committee meeting was adjourned at 1:55pm.		

Employee Fiduciary Subcommittee
(No meeting held in January, 2017)

DRAFT

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
January 10, 2017

Voting Members Present:	Chair Cyril Kellett, Director Leigh Anne Grass, Director Rosemarie Reno, Dr. Gene Ma, Salvador Pilar Joe Quince, Gwen Sanders
Non-Voting Members Present:	Steve Dietlin, CEO; Sharon Schultz, CNE Kapua Conley, COO; Cheryle Bernard-Shaw, CCO; Norma Braun, CHRO; Esther Beverly, VP of HR
Others Present:	Quinn Abler, Frances Carbajal, Director Laura Mitchell
Members Absent:	Dr. Hamid Movahedian, Dr. Martin Nielsen, Virginia Carson

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 12:35 p.m.		Chair Kellett
2. Approval of the agenda	Chair Kellett called for a motion to approve the agenda of January 10, 2017. Gwen Sanders moved and Director Grass seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments from members of the public	Chair Kellett read the paragraph regarding comments from members of the public.	Welcome new board member Leigh Anne Grass to HRC.	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the November 8, 2016 meeting. Director Reno moved and Gwen Sanders seconded the motion. The motion was carried unanimously.		Chair Kellett
5. Old Business			

Topic	Discussion	Action Follow-up	Person(s) Responsible
a. Benefits Broker RFP Update	Norma Braun, CHRO stated she would provide recommendation as to which vendor we should consider as we did with the Lincoln recordkeeper RFP.	The committee agreed.	Norma Braun
6. New Business			
a. B.O.D Dahsboard	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed. Sharon Schultz, CNE expressed satisfaction with new vendor Health Stream vs. Press Ganey.		Chair Kellett
b. Review HR Metrics	Mrs. Braun explained need to postpone results as the calendar year just ended and time is needed to gather accurate metrics, employee turnover and to prepare detailed requested analysis.		Norma Braun
c. Review Key Grievance/ER-LR Data	Mrs. Braun reiterated year end time restraint experienced to prepare current employee and labor relations data in coherence with turnover and metrics analysis.		Norma Braun
d. Review 2017 Draft Work Plan	2017 Draft Work Plan was reviewed & discussed; no changes were recommended		
e. Committee Communications	Reminder: Ethics & Compliance training for members of the board committees on 2.2.17. Next HRC scheduled for third Tuesday of the month 2.21.17 due to FOP needs.		Chair Kellett
f. Date of next meeting	**February 21, 2017**		Chair Kellett
g. Adjournment	Chair Kellett adjourned the meeting at 1:00 p.m.		Chair Kellett

Finance, Operations and [illegible]nning Committee Minutes
January 17, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Kathleen Mendez, Carlo Marcuzzi, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Cheryle Bernard-Shaw, CCO Wayne Knight, Chief Strategy Officer
Others Present	David Bennett, Sharon Schultz, Terry Moede, Dr. Scott Worman, Jane Dunmeyer, Glen Newhart, Ernie Rosales, Kathy Topp, Sherry Miller, Mary Diamond, Charlene Carty, Eva England, Tom Moore, Chris Miechowski, Jeremy Raimo, Priya Joshi, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Dr. John Kroener, Dr. Frank Corona, Tim Keane

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:31 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved to accept the agenda of January 17, 2017.**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Dagostino
4. Ratification of minutes of November 15, 2016	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Kellett, Ms. Mendez seconded, that the minutes of November 15, 2016, are to be approved without any requested modifications. Director Mitchell and Mr. Marcuzzi abstained.**	

Topic	Discussions, Conclusions, Recommendations	Recommendations/ Conclusions	Person(s) Responsible
5. Old Business			
6. New Business			
a. Ethics & Compliance Training Reminder	Director Nygaard emphasized the importance of Committee members attending the Ethics & Compliance training.		Chair
b. Finance, Operations and Planning Meeting Discussion • Regarding Tuesday, November 21, 2017 *(cancellation)* & December 7, 2017 *(reschedule)*		**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommends cancellation of the November 21, 2017 meeting and the December meeting be rescheduled from December 19, 2017 to December 7, 2017.**	Chair
c. Physician Agreement for ED On-Call Coverage – Neurosurgery • Sharona Ben-Haim, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Sharona Ben-Haim as new physician to the existing panel for ED On-Call coverage for Neurosurgery, with no increase in expense. In addition, she requested that this write up be amended to reflect a change in the term of this agreement from 6 to 12 months. Discussion ensued.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Sharona Ben-Haim, M.D. to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning January 1, 2017 and ending December 31, 2017.** Write-up to be amended by Barbara Hainsworth	Sherry Miller
d. Physician Agreement for ED On-Call Coverage – Neurosurgery • Pamela Jones, M.D.	Sherry Miller stated that this write-up is to add Dr. Pamela Jones as new physician to the existing panel for ED On-Call coverage for Neurosurgery, with no increase in expense. In addition, she requested that this write up be	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Pamela Jones,**	Sherry Miller

Topic	Discussions, Conclusions, Recommendations	Recommendations/ Conclusions	Person(s) Responsible
	amended to reflect a change in the term of this agreement from 6 to 12 months. Discussion ensued.	**M.D. to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning January 1, 2017 and ending December 31, 2017.** Write-up to be amended by Barbara Hainsworth	
e. Physician Agreement for ED On-Call Coverage – Orthopedic Surgery • Erik S. Stark, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Erik Stark as new physician to the existing panel for ED On-Call coverage for Orthopedic Surgery, with no increase in expense.	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Erik Stark, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 18 months, beginning January 1, 2017 and ending June 30, 2018.**	Sherry Miller
f. Medical Coverage for CSU Proposal • Coastal Hospitalists	Sharon Schultz explained that this write-up was for the Coastal Hospitalists group to provide medical care, medical consultation and medication orders to patients in the Crisis Stabilization Unit (CSU). This proposal is an addendum to the current contract to provide medical treatment for outpatient behavioral health.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Coastal Hospitalists for five months, beginning February 1, 2017 and ending June 30, 2017 for daily rate of $875, a monthly cost of $26,250, and a total term cost of $131,250.**	Sharon Schultz
g. Physician Agreement of Medical Director of BHU • Mohammad Ahmed, M.D.	Sharon Schultz reported that this agreement was for Dr. Ahmed to act as the Medical Director for the Behavioral Health Unit. He will provide professional guidance, oversight for this area, as well as	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD**	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Recommendations/ Conclusions	Person(s) Responsible
	customary medical director duties as outlined in the agreement. Director Nygaard reported that the motion on this write-up will be corrected to read, "40 hours per month", instead of 40 hours for the month".	**Board of Directors authorize Dr. Mohammad Ahmed as the Medical Director of the BHU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 40 hours per month, at an hourly rate of $150, for a monthly cost of $6,000, and a total cost for the term of $72,000.** Write-up to be amended by Barbara Hainsworth	
h. Physician Agreement of Medical Director of CSU • Mohammad Ahmed, M.D.	Sharon Schultz reported that this agreement was for Dr. Ahmed to act as the Medical Director for the Crisis Stabilization Unit. He will provide professional guidance, oversight for this area, as well as customary medical director duties as outlined in the agreement. Director Nygaard reported that the motion on this write-up will be corrected to read, "40 hours per month", instead of 40 hours for the month".	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Mohammad Ahmed as the Medical Director of the CSU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 40 hours per month, at an hourly rate of $150, for a monthly cost of $6,000, and a total cost for the term of $72,000.** Write-up to be amended by Barbara Hainsworth	Sharon Schultz
i. Physician Agreement for Covering Physician of BHU • Venugopal DePala, M.D.	Sharon Schultz reported that this agreement was for Dr. DePala to provide covering physician duties for the Behavioral Health Unit, when Dr. Ahmed is off. He will provide professional guidance, oversight for this area, as well as customary duties as outlined in the agreement. Director Nygaard reported that the	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. DePala as the Covering Physician for the BHU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 10 hours per**	Sharon Schultz

Topic	Discussions, Conclusions Recommendations	Recommendations/ Conclusions	Person(s) Responsible
	motion on this write-up will be corrected to read, "10 hours per month", instead of 10 hours for the month".	**month, at an hourly rate of $150, for a monthly cost of $1,500, and a total cost for the term of $18,000.** Write-up to be amended by Barbara Hainsworth	
j. Physician Agreement for Covering Physician of CSU • Venugopal DePala, M.D.	Sharon Schultz reported that this agreement was for Dr. DePala to provide covering physician duties for the Crisis Stabilization Unit, when Dr. Ahmed is off. He will provide professional guidance, oversight for this area, as well as customary duties as outlined in the agreement. Director Nygaard reported that there were two corrections to this write-up. The first is that the Terms of the Agreement should be reflected as 12 months, not 1 month, and the motion on this write-up will be corrected to read, "10 hours per month", instead of 10 hours for the month".	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. DePala as the Covering Physician for the CSU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 10 hours per month, at an hourly rate of $150, for a monthly cost of $1,500, and a total cost for the term of $18,000.** Write-up to be amended by Barbara Hainsworth	Sharon Schultz
k. Financials	Ray Rivas presented the financials ending December 31, 2016 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 166,573 Operating Expense $ 166,794 EBITDA $ 10,726 EROE $ 3,095 **TCMC – Key Indicators – FYTD** Avg. Daily Census 182 Adjusted Patient Days 57,118 Surgery Cases 3,141		Ray Rivas

Topic	Discussions, Conclusions, Recommendations	Recommendations/ Conclusions	Person(s) Responsible
	Deliveries 1,363 ED Visits 31,989 **TCHD-Financial Summary – Current Month** Operating Revenue $ 27,606 Operating Expense $ 28,269 EBITDA $ 1,556 EROE $ 317 **TCMC – Key Indicators – Current Month** Avg. Daily Census 180 Adjusted Patient Days 9,456 Surgery Cases 563 Deliveries 200 ED Visits 5,082 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R (in millions) $ 43.1 Days in Net A/R 50.2 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital – Excluding Newborns • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay • TCMC-Emergency Department Visits		
I. Work Plan – Information Only	Director Nygaard reported that these agenda items were for review only, but Committee members were welcome to ask questions.		Chair

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - NEUROSURGERY

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Sharona Ben-Haim, MD

Area of Service: Emergency Department On-Call: Neurosurgery

Term of Agreement: 12 months, Beginning, January 1, 2017 – Ending, December 31, 2017

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Neurosurgery
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$800	FY17: 365	$292,000
	Total:	$292,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurosurgery specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Sharona Ben-Haim, MD to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning January 1, 2017 and ending December 31, 2017.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - NEUROSURGERY

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physician's Name: Pamela Jones, M.D.

Area of Service: Emergency Department On-Call: Neurosurgery

Term of Agreement: 12 months, Beginning, January 1, 2017 – Ending, December 31, 2017

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Neurosurgery
New physician to existing panel, no increase in expense

Rate/Day	Current Panel Days per Year	Current Panel Annual Cost
$800	FY17: 365	$292,000
	Total:	$ 292,000

Position Responsibilities:

- Provide 24/7 patient coverage for all Neurosurgery specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff / Kapua Conley, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Pamela Jones, M.D. to the currently existing ED On-Call Coverage Panel for Neurosurgery for a term of 12 months, beginning January 1, 2017 and ending December 31, 2017.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – ORTHOPEDIC SURGERY

Type of Agreement		Medical Directors	X	Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Erik Stark, M.D.

Area of Service: Emergency Department On-Call: Orthopedic Surgery

Term of Agreement: 18 months, Beginning, January 1, 2017 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Orthopedic Surgery
New physician to existing panel, no increase in expense

Rate/Day		Panel Days per Year	Panel Annual Cost
Monday-Friday:	$1,500	FY17: 365	$564,300
Saturday-Sunday-Holidays:	$1,650	FY18: 365	$564,300
		Total Cost:	**$1,128,600**

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Orthopedic Surgery specialty services in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.

Document Submitted to Legal:		Yes	X	No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Erik Stark, M.D. to the currently existing ED On-Call Coverage Panel for Orthopedic Surgery for a term of 18 months, beginning January 1, 2017 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
MEDICAL COVERAGE FOR CSU PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other:
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Coastal Hospitalists

Area of Service: Crisis Stabilization Unit (CSU)

Term of Agreement: 5 months, Beginning, February 1, 2017 – Ending, June 30, 2017

Maximum Totals:

Daily Rate	Monthly Cost	Total Term Cost
$875	$26,250	$131,250

Description of Services/Supplies: New Service

- Medical Care including History & Physical, medication orders, medical consultation for an average of eight patients per day, 24/7.
- Addendum to the current contract to provide medical treatment for outpatient behavioral health patients.
- This amount is in addition to the already awarded amount of $3,584,000.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:		Yes	X	No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when approved template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive
Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Coastal Hospitalists for five months, beginning February 1, 2017 and ending June 30, 2017 for daily rate of $875, a monthly cost of $26,250, and a total term cost of $131,250.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT FOR MEDICAL DIRECTOR OF BHU

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physicians Name: Mohammad Ahmed, M.D.

Area of Service: Inpatient Behavioral Health Unit (BHU)

Term of Agreement: 12 Months, Beginning, February 1, 2017 – Ending, January 31, 2018

Maximum Totals:

Rate/Hour	Hours per Month	Monthly Cost	12 month (Term) Cost
$150	40	$6,000	$72,000

Position Responsibilities:

- Provide professional guidance and oversight for the Inpatient Behavioral Health Unit (BHU).
- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital and Medical Staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Ahmed as the Medical Director of the BHU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 40 hours per month, at an hourly rate of $150, for a monthly cost of $6,000, and a total cost for the term of $72,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT FOR MEDICAL DIRECTOR OF CSU

Type of Agreement	X	Medical Directors		Panel		Other:
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physicians Name: Mohammad Ahmed, M.D.

Area of Service: Crisis Stabilization Unit (CSU)

Term of Agreement: 12 Months, Beginning, February 1, 2017 – Ending, January 31, 2018

Maximum Totals:

Rate/Hour	Hours per Month	Monthly Cost	12 month (Term) Cost
$150	40	$6,000	$72,000

Position Responsibilities:

- Provide professional guidance and oversight for the Crisis Stabilization Unit (CSU).
- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital and Medical Staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Ahmed as the Medical Director of the CSU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 40 hours per month, at an hourly rate of $150, for a monthly cost of $6,000, and a total cost for the term of $72,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN FOR BHU

Type of Agreement		Medical Directors		Panel	X	Other: Covering Physician
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physicians Name: Venugopal DePala, M.D.

Area of Service: Inpatient Behavioral Health Unit (BHU)

Term of Agreement: 12 Months, Beginning, February 1, 2017 – Ending, January 31, 2018

Maximum Totals:

Rate/Hour	Hours per Month	Monthly Cost	12 month (Term) Cost
$150	10	$1,500	$18,000

Position Responsibilities:

- Provide professional guidance and oversight for the Inpatient Behavioral Health Unit (BHU).
- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital and Medical Staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. DePala as the Covering Physician for the BHU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 10 hours per month, at an hourly rate of $150, for a monthly cost of $1,500, and a total cost for the term of $18,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: January 17, 2017
PHYSICIAN AGREEMENT FOR COVERING PHYSICIAN FOR CSU

Type of Agreement		Medical Directors		Panel	X	Other: Covering Physician
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Physicians Name: Venugopal DePala, M.D.

Area of Service: Crisis Stabilization Unit (CSU)

Term of Agreement: 12 Months, Beginning, February 1, 2017 – Ending, January 31, 2018

Maximum Totals:

Rate/Hour	Hours per Month	Monthly Cost	12 month (Term) Cost
$150	10	$1,500	$18,000

Position Responsibilities:

- Provide professional guidance and oversight for the Crisis Stabilization Unit (CSU).
- Provide supervision for the clinical operation of the Department and Programs.
- Provide staff education to improve outcome of care.
- Resolve conflicts that are intra-departmental or inter-departmental in nature to ensure or improve timeliness of patient treatment and intervention.
- Ensure that services provided are in compliance with regulatory standards.
- Participate in Quality Assurance and Performance Improvement activities.
- Timely communication with primary care physicians and/or other community health resources.
- Documentation: Full and timely documentation for all patients. Comply with all legal regulatory, accreditation, Medical Staff and billing criteria, including applying Medicare guidelines, including, Title 1X for admission and discharge decisions.
- Utilization Review, Quality Improvement: Actively participate in the hospital and Medical Staff's utilization review, quality, performance improvement and risk programs.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:	X	Yes		No
Budgeted Item:	X	Yes		No

*Approval is recommended based on utilizing the approved template. Legal review is not necessary when template is used.

Person responsible for oversight of agreement: Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. DePala as the Covering Physician for the CSU for 12 months beginning February 1, 2017 and ending January 31, 2018. Not to exceed 10 hours per month, at an hourly rate of $150, for a monthly cost of $1,500, and a total cost for the term of $18,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
January 12, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. James Johnson, and Dr. Gene Ma.

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP and Cheryle Bernard-Shaw, Chief Compliance Officer.

Others present: Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Regulatory and Compliance, Jami Piearson, Director for Regulatory Compliance, Cli. Quality and Infection Control, Sherry Miller, Kathy Topp, Chris Michieowski, Nancy Myers, Aimee Hardt, Isabel Escalle, Lisa Mattia, Rowena Okumura, Kathy R. Topp, Mary Diamond, Oska Lawrence, Merebeth Richins, Sharon Davies, Ingrid Stuiver, Patricia Guerra, Sonia Coleman and Karren Hertz.

Members Absent: Dr. Scott Worman and Dr. Contardo.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda and there were no additions or modifications. Director Mitchell briefly introduced Director Leigh Ann Grass to the committee as the new Board member for PAC.	Motion to approve the agenda was made by Director Dagostino and seconded by Director Grass.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of October 2016.	Director Mitchell called for a motion to approve the minutes from October 13, 2016 meeting.	Minutes ratified. Director Dagostino moved and Dr. Ma seconded the motion to approve the minutes from October 2016. Director Grass abstained from voting since she was not present in the previous month's meeting.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Abduction Shoulder Splint Procedure 2. Abduction Splint Application 3. Allied Health Students in Patient Care Areas Policy 4. Cardioversion, Elective	It was noted, as implied by Director Dagostino's question, that the splints in the units are located in the Pyxis supply. There was no discussion on this policy. A clarification made by Director Dagostino indicated that the PT and OT students are covered in this policy as well. The sedation reference component should be added to this policy as Cardioversion procedure almost always requires moderate sedation.	**ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval with the appropriate corrections noted by the Committee members.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
5. Continuous Passive Motion (CPM) Machine Procedure	It was discussed that the regular hospital beds are equipped with extenders for heavy patients.		
6. Epidural or Intrathecal Catheter Infusion in the Non-Laboring patient Procedure	On the PCEA infusion, it should say epidural analgesia; not anesthesia. This procedure is primarily done by anesthesiologists but some neuro physicians do it too on rare occasions.		
7. Fall Risk Procedure and Score Tool Procedure	The hospital uses the Morse Code fall risk scoring system for inpatients while the Emergency Department uses Kinder. The falls assessment are done once a shift and as needed throughout the shift for the purpose of assuring patient safety in the hospital.		
8. Interpretation and Translation Services	It was clarified that the units call in an expert for hearing impaired services. Tablets are still being used for NSL.		
9. Medication Reconciliation Policy	The term Allied Health worker should be changed. CSU is the only unit that AHP is considered since they do their drug administration and reconciliation in the unit. Minor editorial changes were also made to this policy.		
10. Neutropenic Precautions Policy	There was no discussion on this policy		
11. Nursing Students in Patient Care Areas	The checklist of skills that the nursing students need to learn are being tracked by		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Policy	the school rather than the clinical sites. In the chart for the RN Students Skills List, there was a suggestion to make the NOs bold for easier differentiation.		
12. Surgical Skin Stapling	The word "utilize" should be used instead of "fire" in descrbing the automatic staple gun.		
13. Swallowing, Food and Nutrition Considerations for Patients with Oropharyngeal Dyspagia Policy	It was noted that various thickening agents are available on all the units of the hospital.		
Administrative Policies and Procedures:			
1. Decorative Material	There was no discussion on this policy.	**ACTION:** This Administrative policy was approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Unit Specific Emergency Operations Procedure (EOP)			
1. Emergency Operations Plan	Kevin reported that the hospital has a satellite phone for emergency situations in the hospital. If the computers shut down, the facility has enough paper forms that will last for 96 hours. Kevin also added that he had worked with CDCR to devise a plan for the PCU patients admitted in the unit. Sheriff will coordinate the evacuation and care of this population in case a disaster hits the hospital.	**ACTION:** This EOP policy was approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Engineering 1. Equipment Repair 2008 2. Maintenance and Inspection of Medical Gas 2003 3. New Equipment Inventory and Inspection 2007 4. Pre-Purchase Evaluations 2009 5. Purchasing Procedure 2011 6. Scheduled Equipment Maintenance 2006 7. Utility Management Plan 2003 8. Work Order Requests 2010	No discussion on these policies. Chris briefly explained that that the hospital has a computerized system to track all the valves in the hospital.	**ACTION:** The Engineering policies and procedures were approved. Director Dagostino moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Infection Control 1. Aerosol Transmissible Diseases and Tuberculosis Control Plan 2. Standard and Transmission-Based Precautions	It was noted that all of the Infection Control policies are lined up to meet the Joint Commission plan. The discussion centered on rare diseases such as scarlet fever or measles as they present to the ED. Practitioners face a challenge since the incidence of many of these illnesses has declined and many practioners are unfamiliar with some of the	**ACTION:** The Infection Control policies and procedures were approved. Director Schallock moved and Director Finnila seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	signs and symptoms. Since measles and scarlet fever include rashes, the committee was reassured that staff have access to pictures from a variety of sources to aid in the in the assessment process.		
3. Waterborne Illness	Engineers in the hospital test air duct system annually for Legionellosis. There was a suggestion that air samples need to have random checks as precautionary measure for the hospital.		
4. Zika Virus	Lisa mentioned that a couple of Zika cases were reported and sent out straight to CDPH although there were no results given yet.		
Medical Staff			
1. Disaster Privileges	There was a brief discussion on the functions of the practitioners in the event of a disaster. Sherry mentioned that it will take the medical Staff Department 3 days to credential a physician. The Incident Commander will assign the physician according to the needs of the community at the time of the disaster.	**ACTION:** Director Dagostino moved, Dr. Ma seconded and this Medical Staff policy was moved and approved to move forward for Board approval.	Patricia Guerra
NICU			
1. Amphotericin-B Liposome (AmBisome), Ordering and Infusion of	There was no discussion on this policy.	**ACTION:** The NICU policies and procedures were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Consultation to Perinatal Unit	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Women's and Newborn Services 1. Epidural Spinal Management	There was a brief conversation on the epidural procedure; Dr. Johnson mentioned that some RNs are not familiar with the process of assisting when the epidural needs to be done. Sharon Davies will look into this.	**ACTION:** Director Dagostino moved, Director Grass seconded and this Medical Staff policy was moved and approved to move forward for Board approval.	Patricia Guerra
2. Laminaria	The Laminaria is used in the Women's and Children's Services.		
3. Scheduling Process for Procedures	This policy is good as it is being done for a year now.		
4. Shift Change Responsibilities			
5. Vacuum Extraction			
Formulary Requests 1. Fomulary Line Item Additions/ Deletions Deletions: • Albuterol Tablets • Erythromycin/ Sulfixoxazole 200 mg/600 mg suspension • Formoterol 12 mcg (Foradil Aerolizer)	The hospital will stop using the oral Albuterol. This drug has not been in the market for a year now. This medication was stopped 2-3 months ago and the hospital pharmacy is just implementing it right now. The addition of this medication will provide	**ACTION:** The formulary requests were approved. Director Dagostino moved and Dr. Ma seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Zarxio- Admission to Formulary	the hospital with a $60,000 savings for a year.		
6. Clinical Contracts	No contracts were reviewed for this month.	**ACTION:** No action taken.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Ma seconded and it was unanimously approved to go into closed session at 1:00 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 2:10 PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:15 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
January 12th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Abduction Shoulder Splint (Airplane Splint, Don Joy Ultra Sling and ARC Shoulder Brace) Procedure	3 year review, practice change	Forward to BOD for approval
2. Abduction Splint Application (Hip) Procedure	3 year review, practice change	Forward to BOD for approval
3. Allied Health Students in Patient Care Areas Policy	3 year review	Forward to BOD for approval
4. Cardioversion, Elective Procedure	3 year review, practice change	Forward to BOD for approval with revisions
5. Continuous Passive Motion (CPM) Machine Procedure	3 year review, practice change	Forward to BOD for approval
6. Epidural or Intrathecal Catheter Infusion in the Non-Laboring Patient Procedure	3 year review	Forward to BOD for approval with revisions
7. Fall Risk Procedure and Score Tool Procedure	practice change	Forward to BOD for approval
8. Interpretation and Translation Services	1 year review	Forward to BOD for approval
9. Medication Reconciliation Policy	3 year review, practice change	Forward to BOD for approval
10. Neutropenic Precautions Policy	3 year review, practice change	Forward to BOD for approval with revisions
11. Nursing Students in Patient Care Areas Policy	3 year review, practice change	Forward to BOD for approval with revisions
12. Surgical Skin Stapling	NEW	Forward to BOD for approval with revisions
13. Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy	3 year review, practice change	Forward to BOD for approval
Administrative Policies & Procedures		
1. Decorative Material 248	3 year review	Forward to BOD for approval
Unit Specific		
Emergency Operations Procedure (EOP) Manual formerly Disaster Manual		
1. Emergency Operations Plan	1 year review	Forward to BOD for approval with revisions
Engineering		
1. Equipment Repair 2008	3 year review	Forward to BOD for approval
2. Maintenance And Inspection Medical Gas 2003	3 year review, practice change	Forward to BOD for approval
3. New Equipment Inventory And Inspection 2007	3 year review, practice change	Forward to BOD for approval
4. Pre-Purchase Evaluations 2009	3 year review, practice change	Forward to BOD for approval
5. Purchasing Procedure 2011	3 year review, practice change	Forward to BOD for approval

PROFESSIONAL AFFAIRS COMMITTEE
January 12th, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
6. Scheduled Equipment Maintenance 2006	3 year review, practice change	Forward to BOD for approval
7. Utility Management Plan 4003	3 year review, practice change	Forward to BOD for approval
8. Work Order Requests 2010	3 year review, practice change	Forward to BOD for approval
Environment of Care Manual		
1. Fire Safety Hazards	1 year review	Forward to BOD for approval
2. Hazardous Material and Waste Management and Communication Plan	1 year review	Forward to BOD for approval
3. Life Safety Management Plan	1 year review	Forward to BOD for approval
4. Medical Equipment Management Plan	1 year review	Forward to BOD for approval
5. Safety Plan	1 year review	Forward to BOD for approval
6. Security Management Plan	1 year review	Forward to BOD for approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11	1 year review	Forward to BOD for approval
2. Standard and Transmission- Based Precautions - IC 5	3 year review, practice change	Forward to BOD for approval
3. Waterborne Illness - IC 13.1	3 year review, practice change	Forward to BOD for approval
4. Zika Virus	NEW	Forward to BOD for approval
Medical Staff		
1. Disaster Privileges 8710-553	3 year review, practice change	Forward to BOD for approval with revisions
Neonatal Intensive Care		
1. Amphotericin-B Liposome (AmBisome), Ordering and Infusion of	DELETE	Forward to BOD for approval
2. Consultation to Perinatal Unit	NEW	Forward to BOD for approval
Women and Newborn Services		
1. Epidural Spinal Management	3 year review, practice change	Forward to BOD for approval with revisions
2. Laminaria	3 year review, practice change	Forward to BOD for approval
3. Scheduling Process for Procedures	3 year review, practice change	Forward to BOD for approval
4. Shift Change Responsibilities	3 year review, practice change	Forward to BOD for approval
5. Vacuum Extraction	DELETE	Forward to BOD for approval
Formulary Requests		
Formulary Line Items Additions/Deletions: Deletions: • Albuterol tablets • Erythromycin/sulfixoxazole 200mg/600mg suspension • Formoterol 12 mcg (Foradil Aerolizer)	DELETE	Forward to BOD for approval
Zarxio – Admission to Formulary	NEW	Forward to BOD for approval

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ABDUCTION SHOULDER SPLINT ~~(AIRPLANE SPLINT, DON JOY ULTRA SLING, AND ARC SHOULDER BRACE)~~**
Purpose:	To outline the nursing responsibilities in applying and monitoring shoulder abduction splint and applying and monitoring the ~~ultra sling~~**abduction sling with pillow**.
Supportive Data:	An abduction splint is a temporary means of securing a part of the body to maintain alignment and support. A sling is used as a temporary means of securing a part of the body to maintain alignment and support. A brace is used as a temporary means of securing a part of the body to maintain alignment and support.
Equipment:	Shoulder abduction splint ~~(from Orthopedic Technician)~~ **Abduction** ~~Don Joy Ultra~~ Sling **with Pillow** ~~(from Orthopedic Technician)~~ **Abduction and Rotation Control** (ARC) Shoulder Brace ~~(from Orthopedic Technician)~~

~~A. **AIRPLANE SPLINT:**~~

~~1. Assess neurovascular status and skin integrity pre and post-application and ongoing.~~
~~2. Place cushion beneath affected arm with desired angle side up.~~
~~3. Secure cushion by using end of strap with single piece of hook and wrapping it across the chest, behind back and then reattach to itself in front. Make sure cushion does not slide down.~~
~~4. Attach humerus cuff to top of cushion and secure around patient biceps.~~
~~5. Attach wrist cuff at front center of cushion with buckle extending downward and secure wrist to cuff.~~
~~6. Bring shoulder strap over shoulder and attach to swathe strap in back. Adjust buckle for patient comfort and correct fit.~~
~~7. Position head of bed for patient comfort. Place pillow or towels behind affected shoulder for support.~~
~~8. Record application of splint and patient's tolerance in the medical record.~~

~~B.~~**A. ABDUCTION SLING WITH PILLOW~~DON JOY ULTRA SLING~~:**

1. Detach shoulder strap and open front panel, placing arm inside sling with elbow as far back as possible.
2. Secure front strap through the lower D-ring.
3. Affix the snaps**/straps** along the top of the sling to secure the arm in its cradle. The thumb may be placed through the loop inside the sling for additional comfort**, if desired**.
4. Bring the shoulder strap across the back and over the ~~unaffected~~ shoulder and fasten through the middle D-ring of the sling **per manufacturer's recommendation**.
5. Trim shoulder strap by removing the Y tab at the end of the strap and cutting the strap then reapplying the Y tab**, if there is excess strap**.
6. Place the pillow at the waistline with the large end facing forward. Attach the sling to the pillow, lining up the hook and loop strips so they adhere. **The pillow typically has a groove to place at the patient's waist.**
7. Secure the waist strap through the D-ring on the front end of pillow.
8. Position the pillow for desired internal and external rotation by sliding the pillow **anterior**~~forward~~ or **posterior**~~back~~ along the waistline.
9. Position head of bed **a minimum of 30 degrees** for patient comfort. Place pillow ~~or towels~~ behind affected shoulder for support.
10. Document splint application, patient's tolerance, and when the times the splint is on and off in the medical record.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/93, 01/11	02/11, **11/15**	03/11, **12/15**	05/16	04/11, 10/16	05/11, **01/17**	6/00, 7/03, 1/06; 6/08; 05/11

~~C.~~B. **ARC SHOULDER BRACE**:

1. **Brace will be custom fit by outside vendor**
2. **Follow manufacturer's directions for applying brace.**

~~1. Release the ratchet release buckle on abduction arc and shape the formable band to fit the patient's torso.~~

~~2. Position the abduction arc on the affected side of the body at the level of the elbow. Ensure the ratchet release buckle is at the front of the body.~~

~~3. Pass the torso strap around the patient. Insert the ratchet tab end of the torso strap into the ratchet release buckle.~~

~~4. Remove the hook closure at the end of the torso strap and pull the strap to a comfortable tension. If necessary, trim the strap, leaving room for further adjustment. Re-attach the hook closure to secure the end of the torso strap.~~

~~5. Pull the shoulder strap out of the arm cuff. Slip the patient's arm into the cuff. Lift the shoulder strap over the patient's head.~~

~~6. Adjust the shoulder straps length from the front side of the arm sling by pulling it to the desired tension. Adjust the shoulder strap from the back if necessary. Excess strap material may be trimmed if necessary.~~

~~7. Position the neck pad by releasing the hook closure.~~

~~8. Adjust the arm cuff length as needed by lifting the hook closure tabs on the front end of the arm cuff. Fold the arm cuff along the first pre-stitched fold line. Re-attach the hook closure tabs to the inside of the arm cuff.~~

~~9. Adjust the handgrip by placing the patient's handgrip in the patient's hand and adjusting the three tension straps. Re-attach the hook closures.~~

~~10. Adjust the arm support for internal or external rotation. Remove the rubber band from the arm support.~~

~~11. Secure arm cuff to the arm support. Remove the plastic sleeve from the arm support. Ensure a proper attachment by applying gentle pressure to both the arm cuff and the abduction arc strut.~~

~~12.~~3. Document brace application, patient's tolerance, and times the brace is on and off in the medical record.

~~D.~~C. **REFERENCES:**

~~1. Instruction from insert of shoulder abduction splint.~~

~~2. Instruction from company insert, Smith and Nephew 2005.~~

1. ~~Instruction from company application and patient instruction pamphlet, Bledsoe 2007.~~ **National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

~~3.~~2. **NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ABDUCTION SPLINT APPLICATION (HIP)**
Purpose:	To outline the nursing responsibilities when applying an abduction splint **or abduction wedge**.
Supportive Data:	Splints maintain hip abduction to prevent dislocation in total hip replacement patients. Application requires a physician order.
Equipment:	Abduction Splint

A. **APPLICATION:**

1. Verify physician order.
2. Explain procedure to patient.
3. Position splint so the top is as close to patient's perineum as possible.
4. Place patient's leg ~~into grooves~~ on **either side of** the splint.
5. Run dorsal straps under patient's thigh and calf.
6. Bring dorsal straps around patient's leg to anterior section and ~~secure~~ **apply** Velcro straps (~~not too tight~~**snugly, but not restricting venous flow**).
7. Ensure splint is in proper placement prior to turning and/or after repositioning patient.
8. Loosen Velcro straps on patients received from Post-Anesthesia Care Unit (PACU) on arrival to unit and every four hours for skin inspection of pressure points and alignment.
9. Assess splint alignment to patient on arrival to unit and every four hours.
10. Assess patient's skin for pressure points every four hours and PRN.
11. Document presence of abduction splint in the medical record.

B. **REFERENCES:**

~~1. Orthopaedic Nursing, Fourth Edition, 2004; Maher, A., Salmond, S., Pellino, T., W.B. Saunders Co.~~

1. ~~Medical Surgical Nursing, Sixth Edition, Clinical Concepts and Clinical Practice, 2003, Mosby, Inc.~~**National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**
2. **NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/93; 02/11, **10/15**	03/11, **11/15**	03/11, **12/15**	**05/16**	04/11, **10/16**	05/11, **01/17**	5/93, 5/00, 6/00, 7/03, 1/06; 6/08; 05/11

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 5/06	**SUBJECT:** Allied Health Students in Patient Care Areas
REVISION DATE: 7/08; 05/11	**POLICY NUMBER:** VIII.O

Department Approval:	09/16
Clinical Policies & Procedures Committee Approval:	~~09/14~~10/16
Nurse Executive Council Approval:	~~10/14~~10/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/15~~11/16
Professional Affairs Committee Approval:	~~01/15~~01/17
Board of Directors Approval:	01/15

A. **POLICY:**

1. Students from several allied health schools are affiliated with Tri-City Medical Center (TCMC) Allied Health Services (hereafter referred as "allied health").
2. The specific allied health department retains responsibility for allied health care services and related duties where the student is providing care.
   a. For Respiratory Students see Pulmonary Care Services Authorization To Perform (Respiratory Care Students)
   b. Emergency Medical Services (EMS)
      i. Patient care procedures within the Paramedic scope of practice (as established by the State of California and the County of San Diego) may be performed by a Paramedic intern under the direct supervision and guidance of the EMS program instructor, supervising physician or the RN assigned to that patient.
      ii. Emergency Medical Technician (EMT) students in the Emergency Department are only allowed to observe Emergency Department staff in the performance of patient care. EMT students do not provide patient care.
   c. Allied Health Students may only observe in the Pre-Operative Setting.
   d. Imaging Services
      i. Students are required to perform procedures in accordance with published imaging procedure protocols.
      ii. Imaging procedures may be performed by the students under the supervision and guidance of the Clinical Instructor or assigned staff in accordance with the following:
         1) Students use equipment and accessories, employ techniques and perform procedures in accordance with accepted equipment use and radiation safety practices to minimize radiation exposure to patients, selves and others
         2) Medical imaging procedures are performed under **direct supervision** of a qualified practitioner **until** a radiography student achieves competency.
         3) Medical imaging procedures are performed under **indirect supervision** of a qualified practitioner **after** a radiography student achieves competency.
         4) Radiography students repeating unsatisfactory radiographs are under the direct supervision of a qualified practitioner
3. The faculty and students of affiliated schools are responsible for knowing and complying with TCMC Policies and Procedures.

4. The allied health school is responsible for planning the education program and providing Allied Health Services with outlined goals and objectives relating to the clinical experience. The clinical coordinator is responsible for updating and reviewing clinical goals for each student for all department rotations.
5. The allied health clinical coordinator is responsible for establishing orientation dates for the student. Orientation shall include time spent in the department to learn the standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, daily schedules and roles of the staff and students. The student must review the Hospital Orientation for Non Employees of Tri-City HealthCare District Orientation Manual and complete the appropriate orientation paperwork
6. Each student will be assigned a preceptor or specified allied health staff member in their department who will be accountable for all of the student's actions (hereafter referred to as "preceptor").
7. The preceptor has the right and responsibility to intervene or prevent a student from performing any allied health activity that appears inappropriate or potentially injurious to patients. The Director/Operations Manager or designee has the option to discuss behavioral or practice issues with students, preceptors, and school instructors. Staff issues identified by the preceptor are to be directed to the Operations Manager or Director of the unit.
8. Students shall report to work at a specified time to receive report on their assigned patients. The preceptor shall also receive a report (if applicable), which provides current information related to the patient population and identifies potential learning activities for the students. Students shall report to their preceptor before leaving the department.
9. **Student Responsibilities:**
   a. Goal setting, evaluation, communication, and clinical competency.
   b. Participate in primary care of assigned patients including accurate documentation under supervision of preceptor as applicable.
   c. Communicate all pertinent information including finding problems, concerns, and questions or learning needs to preceptor.
   d. Work with all health care and team members in an effective/professional manner.
10. **Handoff/Communication:**
   a. Students must communicate any/all changes in patient status to preceptor.
   b. Students are not to leave the department without reporting to preceptor.
   c. Documentation must be reviewed and co-signed by preceptor as applicable.
   d. All unfinished work is to be reported to the preceptor.
11. **Limitations of Function:**
   a. Students shall not perform any procedures/functions identified without the preceptor present.
      i. Radiography students may perform medical imaging procedures under **indirect supervision** of a qualified practitioner **after** a radiography student achieves competency.
   b. Students may not take verbal or telephone orders.
   c. Students may not perform any procedure requiring specialized certification.
   d. Students may not perform procedures without a physician's order.
12. **Medication Administration:**
   a. All medications shall be administered under the direct supervision of the preceptor following Patient Care Services "Medication Administration" Policy.
   b. Students may only access medications from Pyxis under direct supervision of the preceptor.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CARDIOVERSION, ELECTIVE (SYNCHRONIZED CARDIOVERSION)**
Purpose:	To outline the nursing management of adult/adolescent patients undergoing an elective cardioversion
Supportive Data:	~~Cardioversion may be used to convert hemodynamically stable atrial fibrillation or atrial flutter into normal sinus rhythm~~. Elective cardioversion is performed by ~~a~~the physician only.
Equipment:	1. Defibrillator with functioning synchronizer 2. Multifunction cable and pads **3.** Emergency cart ~~and medication box~~ ~~3.~~**4. Medications as ordered by physician** ~~4.~~**5.** Transcutaneous pacemaker ~~5.~~**6.** Oral airway, manual resuscitation bag with mask, and suction equipment **7.** Automatic blood pressure cuff ~~6.~~**8. Infusion Pump** ~~7.~~**9.** Electrodes

A. **POLICY:**

1. **Elective cardioversions will be performed in procedurales areas, Intensive Care Unit, and Telemetry.**
2. **The Registered Nurses' (RNs) role during an elective cardioversion is to assist the physician as ordered.**
3. **Review Mosby's skill: Synchronized Cardioversion for detailed nursing responsibilities for pre-intra and post-procedure monitoring and assessment.**
4. **Patient undergoing elective cardioversion usually receive procedural sedation, see Patient Care Services Procedure: Sedation Analgesia Used During Therapeutic or Diagnostic Procedures.**

~~.~~B. **PROCEDURE:**

~~17.~~**1.** Initiate Pre-Op/Pre-Procedure Checklist.
~~18.~~**2.** Evaluate laboratory studies prior to the procedure (if available):
   a. Electrolyte levels
   b. Digoxin level
~~19.~~**3.** Note any special circumstances:
   a. Anticoagulation
   b. Permanent pacemaker
      i. Notify company representative to be present per Cardiologist
   c. Implantable cardioverter defibrillator (ICD)
      ~~c.~~**i. Notify company representative to be present per Cardiologist**
   d. Potential airway problems
   e. **Medication**~~Drug~~ allergies
~~20.~~**4.** Gather and check all necessary equipment and supplies.
~~21.~~**5.** Notify and request attendance for respiratory therapist for procedure.
~~22.~~**6.** Keep patient NPO as ordered.
~~23.~~**17.** Establish patent intravenous access and administer IV solution per physician order **using an infusion pump**.
~~24.~~**7.** Position the patient in supine position or as ordered by physician.
~~25.~~**8.** Remove loose-fitting dentures, partial plates, or other mouth prostheses.
~~26.~~**9.** Administer oxygen to patient as appropriate to the condition.
~~27.~~**10. Ensure** ~~Set up~~ suction equipment **is readily available**~~.~~
~~28.~~**11.** Place automatic blood pressure cuff on patient and set for desired time intervals.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
8/00, 3/03, 7/03, 03/04 3/06; 4/09	07/11, **01/16**	08/11, **01/16**	**10/16**	n/a	**10/11, 10/16**	11/11, **01/17**	12/11

~~29.~~**12.** Remove all metallic objects from the patient, as they are conductors of electric current and could result in burns.
~~30.~~**18.** Plug the cord from the defibrillator into the grounded wall outlet.
~~31.~~**19.** Connect patient to ECG monitor on defibrillator.
~~32.~~**20.** Select monitor lead displaying an R wave of sufficient amplitude to activate the synchronization mode of the defibrillator (Lead II preferred).
~~33.~~**13.** Attach multifunction cable to defibrillator and multifunction pads to cable in accordance with the manufacturer's instructions.
~~34.~~**14.** Place the multifunction pads on the patient (apex/sternum or anterior/posterior) as specified by physician in accordance with the manufacturer's instructions.
~~35.~~**21.** Review patient's status and readiness for procedure.
~~36.~~**22.** Administer **medications as ordered**~~intravenous sedation as ordered~~.
~~37.~~**23.** Place defibrillator in synchronization mode. Select energy level as ordered by Physician.
~~38.~~**24.** Turn on ECG and record continuous wave forms.
~~39.~~**18.** Assist physician **with**~~in~~ operating equipment as necessary.
   a. Turn off oxygen ~~at~~ flowmeter during ~~actual~~ cardioversion to decrease risk of combustion.
   b. ~~Announce "I'm clear, you're clear, we're all clear," and e~~**E**nsure all personnel are clear of contact with patient, bed, and equipment during actual cardioversion to prevent from being shocked.
   c. **Post-cardioversion,** ~~R~~restart oxygen after electrical discharge completed.

~~40.~~**19.** Monitor for presence of pulse, and observe monitor for conversion of dysrhythmia immediately after discharge of current. If unsuccessful, the procedure may be repeated with a higher energy level.
~~41.~~**20.** Reorient patient to person, place, and time as temporary altered level of consciousness may occur following cardioversion.
~~42.~~**21.** Continue monitoring per procedural sedation procedure.
~~43.~~**22.** Keep patient NPO until completely awake.
~~44.~~**23.** Obtain 12 lead ECG as ordered by physician.
~~45.~~**24.** Evaluate patient's skin under multifunction pads for burns.
~~46.~~**25.** Document assessment findings **in electronic health record (EHR)** ~~on the Assessment Post-Procedure Powerform~~.
~~47.~~**26.** Document medications administered on the electronic medication administration record (MAR).
~~48.~~**27.** Document patient's response to procedure in the medical record.

C. RELATED DOCUMENTS:

1. **Patient Care Services Procedure: Sedation Analgesia Used During Therapeutic or Diagnostic Procedures**

~~B.~~D. REFERENCE:

1. **American Heart Association (AHA). (2015~~4~~). *Advance cardiovascular life support: Indications for cardioversion.* p. 116.**
2. **Beinart, S. (n.d.) Synchronized electrical cardioversion**
3. **Clinical ~~Mosby's~~ Skills. (2006-2015). Synchronized cardioversion. Retrieved from Tri-City Medical Center (TCMC) intranet.**

~~17.~~**4. Urden, L., Stacy, K., and Lough, M. (2014). *Critical care nursing: Diagnosis and treatment.* Mosby's Inc, St. Louis: MO** ~~AACN. *American Association of Critical Care.* 6th ed., 2011. N. pag. Print.~~

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CONTINUOUS PASSIVE MOTION (CPM) MACHINE**
Purpose:	To outline the nursing management of adult/adolescent patients utilizing a CPM machine.
Supportive Data:	Continuous passive flexion and extension of the knee may speed recovery of function after knee surgery.
Equipment:	CPM Machine

A. **PROCEDURE:**

1. Application requires a physician order.
2. Pad pressure areas with sheepskin.
   a. Keep the opening of the sheepskin padding lined up with the joints of the machine.
   b. Use all Velcro straps making padding taut over bars.
   c. Place long end of padding under the patient's hips, **assure it is free of wrinkles**.
3. Adjust leg length of CPM:
   a. Ensure knee is in bending area of machine and leg is properly aligned.
   b. Ensure foot is in the footplate, leaving enough room in the heel space for the forward motion of the foot during flexion.
      ~~b.~~**i. The CPM flexion joint should line~~like~~ up with the patient's patella.**
   c. Check to make sure footplate has foot at a neutral position to ensure there is no foot drop.
4. Apply and remove CPM machine at full extension **and in the off position**.
5. Slide machine attached to trolley to and from bed.
   a. When not in use, toggle machine on table and release black knob enabling table to fold up. **Do not remove CPM from trolley.**
6. Check alignment every two (2) hours.
7. Remove CPM at least once a shift to check for pressure areas.
8. Inspect skin for pressure areas every four (4) hours.
9. Maintain angle and duration of CPM therapy per physicians order.
   a. Advance angle/flexion as ordered.
10. Remove CPM for meals, bath, and therapy treatment.
11. Remove device if patient complains of unusual pain or discomfort and report findings to physician.
12. Elevate the head of the bed no greater than 30 **degrees**~~.~~, and ensure the knee mechanism **on the bed** is locked in the **OFF** position.
13. Document use, patient tolerance, and angle/flexion in the medical record.

B. **REFERENCE:**

1. ~~Smith, N, and D Pravikoff. *CINAHL Nursing Guide*., 2009. N. pag. Print.~~
2. **National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**
~~2.~~**3. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.**

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Division of Orthopedics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/00; 6/02; 3/03; 7/03, 3/04; 6/06, 6/09; **11/15**	07/11, **12/15**	08/11, **01/16**	**05/16**	10/11, 10/16	11/11, **01/17**	11/11

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**EPIDURAL OR INTRATHECAL CATHETER INFUSION IN THE NON-LABORING PATIENT**
Purpose:	To outline nursing management for the adult inpatient with an indwelling epidural or intrathecal catheter for narcotic administration.
Equipment:	1. Portless Epidural/Intrathecal Administration Set 2. Transparent dressing 3. Alaris infusion pump 4. Epidural/Intrathecal insertion kit 5. Epidural/Intrathecal anesthetic/analgesic solution as ordered by anesthesiologist 6. Blood pressure cuff 7. Pulse oximeter 8. Oxygen delivery equipment & suctioning equipment readily available at bedside 9. Narcan® (Naloxone) 10. Kelly clamp 11. Narcotic administration record/Assessment Record 12. ~~Epidural~~ **Medication** lock box 13. ~~Epidural~~ **Medication** lock box key

A. **DEFINITIONS:**

1. Epidural Infusion: A continuous infusion into the epidural space
2. Epidural Bolus: An intermittent injection via the indwelling epidural catheter
3. Intrathecal Infusion: A continuous infusion into the intrathecal space
4. PCEA infusion: patient controlled epidural ~~anesthesia~~ **anagelsia**

B. **POLICY:**

1. The anesthesiologist/physician and the assigned Registered Nurse (RN) share the responsibility for the observation and monitoring of patients receiving epidural or intrathecal anesthesia.
2. The pharmacy department is responsible for the preparation of the epidural anesthetic/analgesic solution.
3. Only the anesthesiologist/physician may insert the epidural or intrathecal catheter. The lot number and brand of the kit will be documented on the procedure form by the nurse assisting with the procedure.
4. The patient will not be transferred to the next level of care until the epidural setup is connected, and the Alaris pump has been programmed and verified by two (2) RNs.
5. All epidural infusions must be on a dedicated infusion pump with only one module attached, and the **intravenous** (IV) solution contained in an ~~epidural~~ **medication** lock box.
6. Electronic channel label shall be selected via guardrails or channel labels.
7. IV access shall be maintained for at least 8 hours after last dose of epidural medicine or discontinuance of epidural/intrathecal catheter.

C. **PROCEDURE FOR BAG INFUSION DELIVERY:**

1. Initiation:
   a. Obtain physician's order for epidural or intrathecal solution
   b. Spike the epidural/intrathecal solution, or bag with the yellow striped portless tubing after verification of correct dose with 2nd RN, prime the tubing, and thread the tubing through the epidural pump with the ~~epidural~~ **medication** lock box according to manufacturer's instructions.
   c. The epidural will be connected to the infusion tubing and Alaris pump on the sterile field if medication is available.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	**Department of Anesthesiology**	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/07, 06/09, 07/15, **01/16**	07/11, 08/15, **05/16**	08/11, **05/16**	**10/16**	02/07, **11/16**	10/11, **11/16**	11/11, **01/17**	11/11

d. Attach the ~~epidural~~ **medication** lock box.
e. Lock the box containing the epidural/intrathecal solution with the ~~epidural~~ **medication** lock box key stored in the Pyxis.
f. Program the pump, using Guardrails, to the dosing parameters ordered by the anesthesiologist/physician with 2nd RN to verify settings.
g. Start the infusion.
h. Activate the lockout on the Alaris pump controls, located on the back of the infusion device.
i. Return the ~~epidural~~ **medication** lock box key to Pyxis
j. Document on **electronic health record (EHR)** ~~Narcotic Administration Record (NAR)~~ with 2 RNs
k. Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

2. Maintenance:
   a. Administration of bolus or increase:
      i. Boluses must be given through infusion pump, do not break the closed system.
      ii. Program infusion rate on pump per anesthesiologist/physician's order verified with second RN.
      iii. After the bolus, reprogram pump to continuous infusion rate as ordered by anesthesiologist/physician. Verify with 2nd RN.
      iv. Document on **EHR**~~Narcotic Administration Record (NAR)~~
   b. Instruct patient, significant other/family:
      i. Type of pain management
      ii. Frequency and nature of monitoring
         1) Avoid touching or manipulating catheter or tubing.
         2) Avoid excessive moving around or overstretching upper extremities.
         3) Do not get insertion site wet.
      iii. Notify RN if catheter is accidentally removed or if any part becomes disconnected.
      iv. Notify RN if signs of nausea, vomiting, pain, itching, pruritis, severe headache, neck pain, backache, bladder fullness, numbness or tingling or decreased movement or strength in lower extremities.
   c. Changing Infusion Bag:
      i. Hang pre-mixed solution containing the same medication as ordered by the anesthesiologist/physician after verifying with a 2nd RN.

3. Assessment:
   a. Assess for complications that may be associated with epidural initiation.
      i. Local anesthetic toxicity: Assess for drowsiness, light-headedness, tinnitus, circumoral paresthesia, metallic taste in mouth, slurred speech, blurred vision, unconsciousness, cardiac dysrhythmia, and cardiac arrest. Notify anesthesiologist/physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
      ii. High Spinal: Assess for numbness or weakness of the upper extremities, dyspnea, weak speech or inability to speak, apnea and loss of consciousness. Notify anesthesiologist/physician immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation as needed.
      iii. Hypotension: Position patient in lateral position, notify anesthesiologist/physician, and administer intravenous fluid bolus if ordered.
   b. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate every 1 hour times 2; every 2 hours times 6; **then** every 4 hours until epidural or intrathecal catheter is discontinued.
      i. If dose is increased or bolus given, assess and document every 1 hour times 2; every 2 hours times 6; **then** every 4 hours until epidural or intrathecal catheter is discontinued.

c. Assess epidural or intrathecal catheter or tubing
   i. Every 4 hours, verify the portless tubing is connected to the epidural or intrathecal catheter.
   ii. Every shift, verify catheter, infusion tubing, epidural or intrathecal pump, and epidural or intrathecal solution are properly labeled.

d. Assess insertion site
   i. Every 4 hours, verify catheter site is clean, dry and intact without signs of edema, drainage or infection

e. Monitor sensory and motor function of lower extremities every 4 hours, and before and after catheter removal

f. Monitor for the following possible side effects every 4 hours, and see physician orders for appropriate intervention as needed:
   i. Change in level of consciousness.
   ii. Nausea and vomiting
   iii. Itching, pruritis
   iv. Urinary retention
   v. Loss of motor function, strength, and sensation of lower extremities
   vi. Before and after ambulation Before and after epidural catheter removal

g. Assess and document sedation level, pain level, pulse oximetry, blood pressure, heart rate, and respiratory rate documented every 1 hour times 2; every 2 hours times 6 **then** every 4 hours until epidural or intrathecal catheter is discontinued. If stable, resume previous vital signs order.

h. If disconnection from the catheter tubing is suspected, cover with sterile gauze, and notify Anesthesiologist. DO NOT USE OR ALCOHOL OR ATTEMPT TO RECONNECT.

D. **PROCEDURE FOR SYRINGE DELIVERY DEVICE FOR PCEA:**

1. Obtain physician's order for epidural or intrathecal solution
2. Obtain solution filled syringe from Pharmacy and connect the yellow striped portless tubing to the syringe after verifying correct dose with 2nd RN. Prime tubing.
3. For PCEA, the nurse will confirm epidural solution concentration and pump settings as ordered by anesthesiologist/physician (i.e. rate mL/hr, bolus amount/ml). Lockout must be documented in patient care record and verified by 2 RN's.
4. Insert the syringe into the Alaris pump
5. Program the Alaris pump, using Guardrails, to the dosing parameters ordered by the physician and verify settings with 2nd RN.
6. ~~The lock box will be pre-labeled "Epidural" to indicate its use for epidural/intrathecal infusion, with a directive to return to SPD after individual use is completed and therapy discontinued.~~
7. ~~7.~~**6.** Start the infusion.
8. ~~8.~~**7.** Engage the lockout feature on the Alaris pump.
9. ~~9.~~**8.** Return the ~~epidural~~ **medication** lock box key to Pyxis.
10. ~~10.~~**9.** Document on the **electronic health record (EHR)** ~~Narcotic Administration Record (NAR)~~ with **two**~~2~~ RNs for **Patient controlled anagesia** (PCAs) and epidurals.
11. ~~11.~~**10.** Provide positioning assistance and emotional support to the patient during the epidural initiation procedure.

E. **REMOVAL OF EPIDURAL OR INTRATHECAL CATHETER:**

1. Verify written physician order to remove catheter.
2. Place patient in relaxed position.
3. Assess patient for back pain, back tenderness and baseline motor strength and sensation prior to removal of the catheter.
4. Assess site for hematoma, drainage and signs of infection.
5. Stop infusion and clamp tubing. Document final volume readings.
6. Perform hand hygiene.

7. Remove dressing while maintaining pressure on tubing just above insertion site. **Do not use alcohol. (Alcohol is neurotoxic to epidural space.)**
8. Gently and steadily remove catheter with one slow motion while holding 2x2 gauze over the site. If patient develops pain or parasthesia or resistance is met, STOP procedure, place a sterile dressing over site to secure epidural or intrathecal line, and notify anesthesiologist/physician.
9. Verify catheter tip is intact and rounded once catheter is removed.
10. If tip is missing:
    a. Notify physician.
    b. Place the catheter with the missing tip in a specimen bag and label with the patient's name, date of removal
    c. Give ~~to~~ the ~~shift supervisor on duty in your work location.~~**specimen bag with the tip to the ANM/relief charge.**
11. Place sterile dressing over the area and apply pressure for at least 2 minutes.
12. Evaluate patient's motor strength and sensation. Notify physician for decreased motor strength and/or sensation.
13. Document procedure and patient response.
14. Waste unused medication per the Wasting Narcotics procedure and lock box.
15. Return lock box and Alaris pump to SPD.
16. Return ~~epidural~~ **medication** lock box key to unit Pyxis.
17. Special Considerations for Anticoagulated Patients:
    a. Check prothrombin time (PT) levels and platelet level where applicable. For elevated PT levels, or platelet level less than 50,000, consult physician prior to removal.
    b. Record neurological exam of the lower extremities every 1 hour times 2 hours, every 2 hours times 2 hours, every 4 hours times 2 hours after removal of the catheter.

F. REFERENCES:

1. Besuner, P. (2007). Association of **w**~~W~~omen's **h**~~H~~ealth, **o**~~O~~bstetric and **n**~~N~~eonatal **n**~~N~~urses - Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC.
2. Cohen, S.P. & Dragovich, A. (2007, December). Intrathecal anesthesia. *Anesthesiology Clinics*, 25(4). Retrieved ~~December 2, 2008 from~~ http://www.mdconsult.com
3. Grant, P.J. & Wesorick, D.H. (2008, March). Perioperative medicine for the hospitalized patient. *Medical Clinics of North America*, 92(2). Retrieved from http://www.mdconsult.com
4. Gregoretti, C. et al (2007, March). Regional anesthesia in trauma patients. *Anesthesiology Clinics,* 25(1). Retrieved from http://www.mdconsult.com
5. ~~Perry, A.G. & Potter, P.A. (2006). *Patient controlled analgesia.* Clinical Nursing Skills & Techniques (6th ed.). Retrieved from http://app32.webinservice.com/MosbySkills/SkillDetails~~
5. **Mosby's Skills. (2014) Medication administration patient controlled analgesia. Retrieved from TCMC intranet.**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**FALL RISK PROCEDURE AND SCORE TOOL**
Purpose:	To provide a comprehensive fall risk assessment on all patients each shift and implement appropriate fall risk interventions based upon the patient's identified fall risk factors.
Supportive Data:	Inclusive of all inpatient areas. Requires a Registered Nurse (RN) to evaluate and identify risk factors for falls, develop an appropriate plan of care for prevention, perform a comprehensive evaluation of falls that occur, and revise the plan of care as appropriate for fall prevention.
Equipment:	Fall Risk Score Tool

A. **PROCEDURE:**

1. **The RN completes the Morse** Fall Risk Assessment ~~is completed~~ on every patient**, including visually assessing and interviewing the patient,** ~~by the RN~~ to determine the patient's fall risk **score and secondary risk factors**~~level. on admission or transfer and on every shift until the patient is discharged from the medical center.~~:
   a. ~~Complete the Morse Fall Risk Assessment Tool in the electronic health record. Interview all patient to assess the risk of fall and to identify factors secondary to fall risk.~~
      i. Upon admission to the hospital
      ii. Upon admission or transfer to another level of care area~~.~~
      ~~i.~~**iii. Once a shift**
      ~~ii.~~**iv.** After any fall occurs
      v. When there is a change in the patient's status (physiological, functional, or cognitive)
2. Review the patient's medications for any that may alter the patient's ambulatory stability **(see Medication Fall Alert Reference Text)**.
3. All patients receive the following Universal Fall Precautions as appropriate:
   a. Adequate lighting
   b. Assistive devices within easy reach
   c. Bed in low position
   d. Bed wheels and wheelchair brakes locked
   e. Assure call light **and** ~~within~~**possessions are within** easy reach
   f. Clean and dry surfaces
   g. Hand rails and grab bars **accessible** ~~within easy reach~~
   h. **Hourly rounding**
   i. Non-skid slippers **or footwear are worn during ambulation**
   j. Orient~~ation~~ **patients to their bed area, unit facilities, and how to get assistance** ~~to environment~~
   k. Patient/family fall prevention education (uses the Patient **and Family Guide** ~~Handbook and highlight the patient safety section~~ **and review Fall Prevention section).**
   ~~k.~~**l.** Rooms free of clutter
   ~~l.~~**m.** Side rails up **times**~~X~~ 2
4. The patient's primary RN shall implement an individual Interdisciplinary Plan of Care for fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the Interdisciplinary Plan of Care. These include but are not limited to:
   a. Low Risk Patients (= 0 - 35 total score):
      ~~i. Orient patients to their bed area, unit facilities, and how to get assistance.~~
      ~~ii. Call bell/light for patients and ensuring it is placed within reach of patient~~
      ~~iii. Involving family in the care of the patient~~
      ~~iv. Follow-up with individual caregivers~~

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
6/06, 1/08, 6/09, 09/15, **04/16**	11/11, 10/15, **06/16**	11/11, 10/15, **7/16**	**n/a**	11/15, **11/16**	2/12, 01/16, **01/17**	2/12, 1/16

~~v. Stabilize beds and bedside furniture~~
~~vi.~~**i.** **Reinforce use of** ~~Utilize~~ grab bars near toilets.
ii. **Reinforce possible medication side effects that could increase risk of falling**.~~Review prescribed medications every shift~~
~~vii.~~**iii.** Limit **administration of** combinations of medications **that may increase fall risk** when possible.
~~viii. Ensure the patient is able to reach necessary items (phone, water, call light/bell)~~
~~ix. Use safety measures in chairs and wheelchairs~~
~~x. Use geriatric chairs~~
~~xi.~~**iv.** Select suitable chairs with armrests that are an appropriate height for rising and sitting.
~~xii.~~**v.** **Encourage patient to move/change position** ~~Instruct patients to rise~~ slowly.
~~xiii. Offer material to assess for a fall risk free home~~
~~xiv.~~**vi.** Place patients with urgency near toilets or use commodes.
~~xv.~~**vii.** Instruct male patients prone to dizziness to sit while voiding.

b. Moderate Risk Patients (= 36 - 44 total score):
i. Implement **Universal and** Low Risk interventions.
~~ii. Educate the patient and family about the risk of falling, safety issues and mobility limitations~~
~~iii. "Patient Safety/Preventing Slips and Falls" handout shall be provided to patient and family~~
~~iv. Offer toileting every 2 hours to patients who are receiving laxatives or diuretics~~
~~v.~~**ii.** Ambulate patients with assistance.
~~Teach patients to make position changes slowly~~
~~vi.~~**iii.** Re-orient confused patients.
~~vii.~~**iv.** Move confused patients close to nurse's station.
~~viii.~~**v.** Encourage family members to sit with confused patients.
~~ix.~~**vi.** Use bed exit alarms.
~~x.~~**vii.** Use chair alarms.
~~xi.~~**viii.** Teach activity limits to patient and family.
~~xii.~~**ix.** Large ~~"Yellow Stoplight~~**fall risk** ~~Laminates~~ **sign**~~"~~ shall be placed at the head of the bed for moderate risk patients ~~and small "Yellow Stoplight Laminates" shall be placed on the patient's medical chart~~.
x. A ~~"stoplight~~ **fall** ~~" magnet~~**risk magnet** shall be placed on the patient's doorframe with the designated bed indicated on the magnet ~~using a black sharpie pen~~.
~~xiii.~~**xi.** **Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.**

c. High Risk Patients (= 45+ total score) require:
i. Implement **Universal,** Low, and Moderate Risk interventions.
ii. Place ~~designated color-coded~~ **fall risk** wristband on patient.
a. High Risk Rounding**: strongly encourage patient to use the bathroom or Bedside Commode at least every 4-6 hours while awake if they have not gone when offered during hourly rounding (does not include patients with ~~foleys~~Foleys).**~~Rounds on assigned patients shall be made every hour by the RN, Licensed Vocational Nur), or desi-~~
~~b. Hourly rounding shall be documented in the electronic medical record at the end of each shift.~~
iii. **Remain with patient while toileting or showering if appropriate.**
iv. **Ensure commode is available at bedside if patient is unable to ambulate to the bathroom with assistance.**
~~iii. Large "Red Stoplight Laminates" shall be placed at the head of the bed for high risk patients and small "Red Stoplight Laminates" shall be placed on the patient's medical chart.~~

d. Responsibilities:
   i. ~~Designated color-coded~~**Fall Risk** Armbands
      a. The RN or ~~LVN~~ **Designee** is responsible for placing the armbands on the wrist of patients identified as high (45+) risk.
      b. The RN or ~~LVN~~**Designee** is responsible for removing the armband upon change in Fall Risk Score or upon discharge.
   ii. Large ~~"Stoplight~~**Fall Risk**~~"~~ Laminates
      a. The RN or ~~LVN~~**Designee** is responsible for placing, updating, and/or removing the large ~~"stoplight~~**Fall Risk**~~"~~ laminates over the head of the patient's bed.
   ~~iii. Small "Stoplight" Laminates~~
      ~~a. The RN or LVN is responsible for placing, updating, and/or removing the small stoplight laminate on the patient's chart~~
   ~~iv.~~**iii.** ~~"Stopligh~~**Ftall risk**~~"~~ ~~M~~**m**agnets:
      a. The RN or ~~LVN~~**Designee** is responsible for placing, updating, and/or removing the ~~"stoplight~~**fall risk**~~"~~ magnet on the patient's doorframe with the designated bed indicated on the magnet. ~~using a black sharpie pen.~~
   ~~v.~~**iv.** The **Assistant Nurse Manager (ANM)**/charge nurse shall check for appropriateness of signage during rounds.
e. The primary RN shall reassess the patient every shift for needs and change in status.
   i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.
f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change or the absence of family.
g. The patient's fall risk status and family presence shall be reported during communication hand-offs.
h. If a patient falls, the ~~Assistant Nursing Manager~~**ANM** or ~~designee~~**designee** shall conduct an immediate educational debriefing for all staff involved.
   i. A Quality Review Report (QRR) and Post Fall ~~Risk Analysis~~**Huddle** shall be completed by the Assistant Nursing Manager or ~~designee~~**designee**
   ii. The QRR and Post Fall ~~Risk Analysis~~**Huddle** shall be reviewed by the Director/Manager and ~~forwarded to~~ Risk Management~~.for review within 24 hours~~.
i. Each outpatient care area and Emergency Department will assess the risk for falls based on their own unit specific guidelines, and intervene as appropriate.
~~j. All patients are reassessed prior to discharge for their stability: dizziness, observe ambulation assisted and unassisted, educate on fall prevention, rescore and document.~~

B. **SPECIAL CONSIDERATIONS:**

1. **Intensive Care Unit (ICU) Specific Fall Precautions**
   a. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:
      i. Stoplight magnets and overhead laminates are not required.
      ii. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
   b. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team **Technician** assistance with getting out of bed (requires physician order).
2. **Peri-Anesthesia (PANS) Specific Fall Precautions**
   a. All patients in PANS area are considered high fall risk due to post anesthesia / sedation status.
   b. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
      i. Including call light within reach of bedside.

ii. Patients shall be assisted to bathroom and ambulated wearing shoes or non slip socks.
iii. RN family member in attendance behind curtain to assist out-patient while dressing prior to discharge.

c. ~~Stoplight~~ **Fall Risk** magnets and overhead laminates are not required.

3. **Emergency Department (ED) Specific Fall Precautions**
   a. **Patients seen in the ED are scored for falls using KINDER1 Falls Scale, which is an evidenced based best practice tool developed specifically for Emergency Departments.**
   b. **Fall risk assessment is performed by an RN upon initial assessment.**
      i. **The patient is deemed not at risk.**
      ii. **The patient is deemed at risk if there is a yes answer to any question.**
   c. **Reassessments are performed with any change of condition.**
   d. **If a patient falls in the ED the patient automatically becomes an at risk for falls patient.**
   e. **The following interventions are instituted based on the patient's risk value:**
      i. **Universal Falls precautions are initiated on all patients in the Emergency Department.**
      ii. **At risk for falls precautions (include but not limited to):**
         a. **Encourage family to remain with patient**
         b. **Encourage patient to change position slowly**
         c. **Increase intervals of nursing observation**
         d. **Patients shall be assisted to bathroom and with ambulation**
         e. **Fall Risk armband placed on patient**

4. **Imaging Services**
   a. **See Imaging General Safety Policy for Unit Specific Interventions**

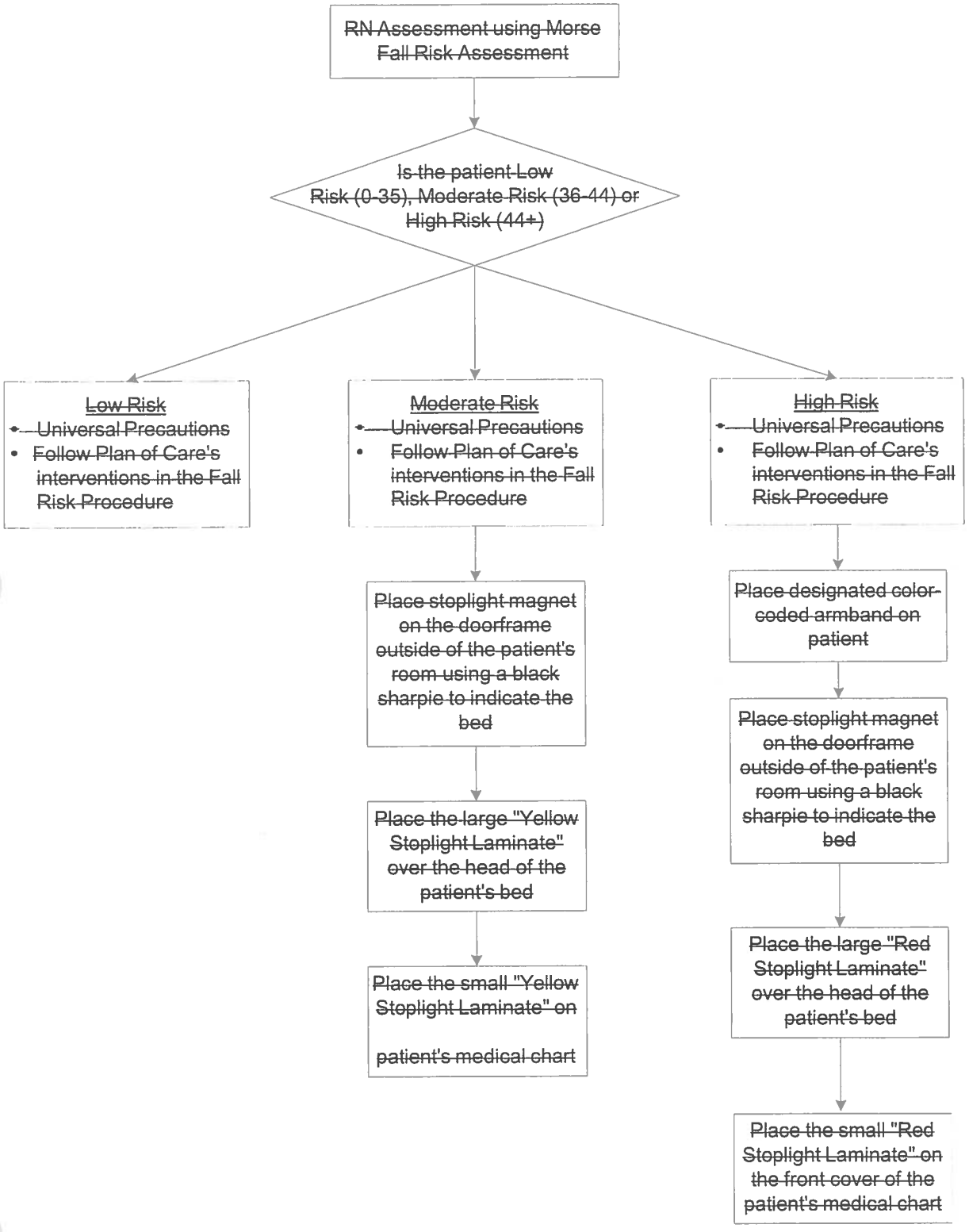
C. **RELATED DOCUMENTS:**

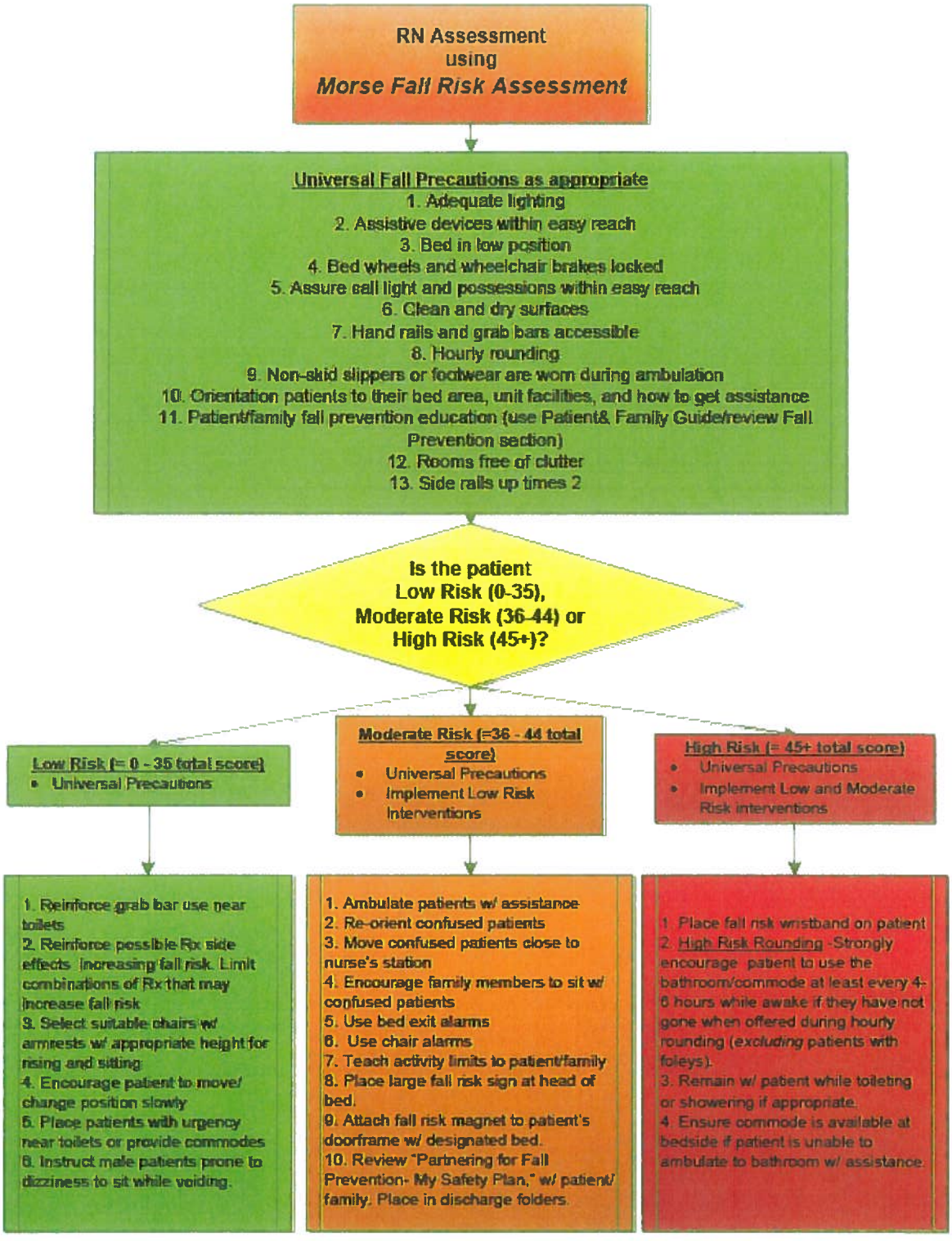
1. **Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions**
2. Fall Risk Algorithm
3. **Medication Fall Alert Reference Text**
4. **Partnering for Fall Prevention- My Safety Plan - Sample**
5. Post ~~Patient~~ Fall Huddle ~~& Analysis Tool~~ **- Sample**

~~Unit Specific Fall Precautions~~

DELETE – New 2016 Version replacing this.

Fall Risk Procedure Algorithm




RN Assessment
using
Morse Fall Risk Assessment
Universal Fall Precautions as appropriate
1. Adequate lighting
2. Assistive devices within easy reach
3. Bed in low position
4. Bed wheels and wheelchair brakes locked
5. Assure call light and possessions within easy reach
6. Clean and dry surfaces
7. Hand rails and grab bars accessible
8. Hourly rounding
9. Non-skid slippers or footwear are worn during ambulation
10. Orientation patients to their bed area, unit facilities, and how to get assistance
11. Patient/family fall prevention education (use Patient& Family Guide/review Fall Prevention section)
12. Rooms free of clutter
13. Side rails up times 2
Is the patient
Low Risk (0-35),
Moderate Risk (36-44) or
High Risk (45+)?
Low Risk (= 0 - 35 total score)
• Universal Precautions
Moderate Risk (=36 - 44 total score)
• Universal Precautions
• Implement Low Risk Interventions
High Risk (= 45+ total score)
• Universal Precautions
• Implement Low and Moderate Risk interventions
1. Reinforce grab bar use near toilets
2. Reinforce possible Rx side effects increasing fall risk. Limit combinations of Rx that may increase fall risk
3. Select suitable chairs w/ armrests w/ appropriate height for rising and sitting
4. Encourage patient to move/ change position slowly
5. Place patients with urgency near toilets or provide commodes
6. Instruct male patients prone to dizziness to sit while voiding.
1. Ambulate patients w/ assistance
2. Re-orient confused patients
3. Move confused patients close to nurse's station
4. Encourage family members to sit w/ confused patients
5. Use bed exit alarms
6. Use chair alarms
7. Teach activity limits to patient/family
8. Place large fall risk sign at head of bed.
9. Attach fall risk magnet to patient's doorframe w/ designated bed.
10. Review "Partnering for Fall Prevention- My Safety Plan," w/ patient/ family. Place in discharge folders.
1. Place fall risk wristband on patient
2. High Risk Rounding -Strongly encourage patient to use the bathroom/commode at least every 4-6 hours while awake if they have not gone when offered during hourly rounding (excluding patients with foleys).
3. Remain w/ patient while toileting or showering if appropriate.
4. Ensure commode is available at bedside if patient is unable to ambulate to bathroom w/ assistance.

Morse Fall Scale

Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	_____
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	_____
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	 0 15 30	_____
4. Intravenous therapy/heparin lock	No 0 Yes 20	_____
5. Gait Normal/bedrest/wheelchair Weak* Impaired†	 0 10 20	_____
6. Mental status Oriented to own ability Overestimates/forgets limitations	 0 15	_____
Total Score‡: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		_____

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

Medication Fall Alert Reference Text

Medications (including but not limited to) that may affect Patients Fall risk

~~***Denotes individual drugs associated with highest risk of dizziness or falls in each category***~~

Category One

1. Antihistamines
   - a. Chlorpheniramine (Chlor-Trimeton)
   - b. Diphenhydramine Hydrochloride (Benadryl)
   - c. Dimenhydrinate (Dramamine)
   - d. Hydroxyzine (Vistaril)
   - e. Meclizine (Antivert)
2. Cardiac Drugs
   - f. Atenolol (Tenormin)
   - g. Captopril (Capoten)
   - h. Diltiazem (Cardizem)
   - i. Enalapril (Vasotec)
   - j. Lisinopril (Zestril)
   - k. Metoprolol (Lopressor)
   - l. Nifedipine (Procardia)
   - m. Propranolol (Inderal)
   - n. **Amiodarone (Cordarone)**
3. Hypotensive Agents
   - a. Clonidine (Catapres)
   - b. Hydralazine (Apresoline)
   - c. Labetalol (Trandate)
   - d. Prazosin (Minipress) (Especially first dose syncope)
   - e. Terazosin (Hyrtin) (Especially first dose syncope)
   - f. Doxazosin (Cardura) (Especially first dose syncope)

Category Two

a. Neurotoxic Chemotherapeutic Drugs
   - a. Ifosfamide (Ifex)
   - b. Vincristine (Vincasar)
   - c. Cisplatin
   - d. Methotrexate
   - e. Cytarabine
   - f. 5-fluorouracil (Adrucil)
   - g. Paclitaxel

b. Vasodilating Agents
   - h. Isosorbide dinitrate (Isordil)
   - i. Isosorbide mononitrate (Imdur)
   - j. Nitroglycerin (Nitrostat)

c. Opiate Agonists
   - k. Codeine (Includes cough syrups and Tylenol #3)
   - l. Hydrocodone (Norco)
   - m. Morphine
   - n. Oxycodone (Percocet)
   - o. **Tramadol (Ultram)**

d. Anticonvulsants
   - p. Phenobarbital
   - q. Diazepam (Valium)
   - r. Phenytoin (Dilantin)
   - s. Carbamazepine (Tegretol)

e. **Muscle Relaxants**

a. Baclofen (Lioresal)
b. Carisoprodol (Soma)
c. Cyclobenzaprine (Flexeril)
d. Chlorzoxazone (Lorzone)
e. Metaxalone (Skelaxin)
f. Methocarbamol (Robaxin)
g. Orphenadrine (Norflex)

Category Three

1. Psychotherapeutic Agents
   a. Clomipramine (Anafranil)
   b. Amitriptyline (Elavil)
   c. Doxepin (Silenor)
   d. Sertraline (Zoloft)
   e. Trazodone (Oleptro)
   f. Imipramine (Tofranil)
   g. Trimipramine (Surmontil)
2. Antipsychotic Agents
   h.
   i. Chlorpromazine (Thorazine)
   j. Clozapine (Clozaril)
   k. Thioridazine
3. Benzodiazepines
   l. Alprazolam (Xanax)
   m. Chlordiazepoxide (Librium)
   n. Flurazepam
   o. Lorazepam (Ativan)
   p. Temazepam (Restoril)
   q. Triazolam (Halcion)
4. Diuretics
   r. Furosemide (Lasix)
   s. Bumetanide (Bumex)
   t. Torsemide (Demadex)
5. Miscellaneous Anxiolytics, Sedatives & Hypnotics
   Meprobamate

Partnering for Fall Prevention – My Safety Plan Sample

Directions: This is a tool to partner with the patient and family for education of the patient's fall risk factors and strategies to reduce risk of falls and keep the patient safe.

Partnering for Fall Prevention - My Safety Plan

We care about you and your safety. We want to partner with you and your family to prevent falls. Your medical assessment shows you to be at risk for falls.

You are at risk for falls or injury because:

- ☐ You are unsteady when you walk.
- ☐ You may bleed easily if you fall.
- ☐ You are taking medications that may make you fall more easily.
- ☐ Your medical history shows an increased risk for broken bones, due to: _____
- ☐ Recent surgeries or procedures put you at risk for falling, such as:_____
- ☐ Medical equipment (sequential devices, foot pumps, etc.) _____
- ☐ Other:_____

What you and your family can do to help us keep you safe

For Patients at risk for falls we ask that you do the following:

- ➢ I know how to use my call light
  - ☐ RN: Pt demonstrated correct use of call light to notify nursing staff
- ➢ I will always use the call light to contact the nurse. I promise to stay in bed and call my nurse for help.
  - o Whenever I need to get up
  - o Whenever I need help reaching something that is out of my reach
  - o Whenever I am feeling dizzy or sleepy from medications
- ➢ I will always call the nurse and not ask family for help getting out of bed
- ➢ I will wear my skid-proof slipper socks and yellow wrist band
- ➢ I have a bed alarm that is active at all times. It will alert nursing staff when I am out of bed. I will not turn off the alarm.
- ➢ I will not use the over-bed table to help me stand; it is on rollers and may cause me to fall if I lean on it.

☐ RN: Reviewed falls prevention plan with patient and family

atient Initials/Date/Time:_____

RN Signature/Date/Time:_____

POST FALL HUDDLE/AFTER ACTION REVIEW - Sample

Date: / /_____Time:_____

Setting:_____FIN #:_____Entered By:_____

Reason for Audit: To involve front line staff in identifying problems and solutions, and in creating change in their work environment. To promote trust and team building among team members. To promote a positive Culture of Safety without individual blame.

Instructions:
1. Hold the Huddle as soon as possible and after every fall.
2. Involve the patient, staff involved in the care of patient or fall, and assistant nurse manager or manager. 3. Meeting is organized by primary RN and is brief.

** Indicates that an answer is required.*

2013 Post Fall Huddle/ After Action Review

2013 Post Fall Huddle	Answer	Comments
1.* Why did this patient fall? Ask the group "why" 3 times to find the root cause. Example: Why did this patient fall? The patient got out of bed alone because he had to go to the bathroom.		*Lessons Learned*
2.* Why did "answer to question 1" happen? Example: Why did the patient get out of bed alone? The patient got out of bed alone because he did not know where his call light was.		*Lessons Learned*
3.* Why did "answer to question 2" happen? Example: Why did he not know where his call light was? The call light was not within reach of the patient.		*Lessons Learned*
4.* What was the latest Fall Risk Score for the patient?		
Were the appropriate interventions in place?	Yes | No	*What accounted for the difference?*
6.* How could the same outcome be avoided next time?		*Lessons Learned*
7.* What is the follow up plan?		*Follow up Plan*
8. Patient's account (if able to share)		*Patient's Account*
9. Agreement with patient for safety (Promise to use call bell; return demo how to use call bell)		*Safety Agreement*
10.* Type of Fall? Definitions for Type of Falls Accidental falls- Slipping, tripping, person making errors of judgement Anticipated physiological falls- Related to age and functional ability, Disease(s), Previous Fall(s), Weak or impaired gait, Lack of realistic assessment of their own ability, Person making errors of judgment. Unanticipated physiologic falls- Attributed to physiological causes but created by conditions that cannot be predicted Behavioral falls- Patient who has behavioral issues and voluntarily positions his/her body from a higher level to a lower level.		
Accidental Fall	[ ]	
Anticipated Physiological Fall	[ ]	
Unanticipated Physiological Fall	[ ]	
Behavioral (Intentional) Fall	[ ]	
11.* Post Fall Checklist		
RL Completed	[ ]	
IPOC Post Fall Initiated	[ ]	
Physician Notified	[ ]	
Documentation in the Medical Record (event, phys exam, intervention)	[ ]	
Morse Fall Risk Score Updated	[ ]	

DELETE – replaced with new document

Post Patient Fall Huddle & Analysis Tool

Purpose: To provide a mechanism to immediately analyze all patient falls when they occurred to evaluate potential opportunities for the immediate re-assessment of the patients falls risk indicators, to develop a plan for the prevention of additional falls, and to highlight and correct any environmental barriers that may have contributed to the initial fall.

Patient ID:_____ Date of Fall:_____ Time of Fall:_____ Loc

Previous Falls Risk/Lift Assessment category (circle one):

Low Risk (0-35)
Moderate Risk (36-44)
High Risk (44 and higher)

Patient Interview:
(include statement from patient about why the fall occurred):

Check all Fall Risk Factors present

Psychotropic, analgesics, diuretics, anticoagulants or XXX medication usage within past 12 hours
Noted urinary frequency or diarrhea
Documented agitation, confusion, or disorientation
Utilization of the equipment that could contribute to ambulation problems
Call light unavailable for use
Patient incontinent
Attempting to toilet alone without assistance or equipment
Patient alone, family member non present
Room and floor area cluttered
Patient lift assistive equipment not available or not used
Shackles

Outcomes of falls:

No injury
Minor abrasion, contusion or laceration
Fracture
Death
Prevention Plan:

Patient re-educated about importance of calling for assistance
Family re-educated about importance of utilizing assistance
Reinforce patient safety with patient and family through use of lift equipment
Bed alarm
Chair alarm
Leave light on at all time
Increase frequency of rounds to offer toileting, hydration, and assessment of condition
Obtain patient sitter
Increase utilization of lift assistive equipment (bed to chair/commode transfers, sit to stand and ambulation for toileting)
Assist to floor
Unwitnessed Fall
Witnessed Fall
Appropriate Documentation
Head to toe assessment
Other:

DELETE - Incorporate content into procedure instead of a related document.

~~UNIT SPECIFIC FALL PRECAUTIONS~~

~~INTENSIVE CARE UNIT (ICU) SPECIFIC FALL PRECAUTIONS~~

~~A. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:~~
~~1. Stoplight magnets and overhead laminates are not required.~~
~~2. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.~~
~~B. Moderate and/or high-risk patients require RN, Physical Therapist, or Lift Team assistance with getting out of bed (requires physician order).~~

~~PERI-ANESTHESIA (PANS) SPECIFIC FALL PRECAUTIONS~~

~~A. All patients in PANS area are considered high fall risk due to post anesthesia / sedation status.~~
~~B. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.~~
~~1. Including call light within reach of bedside.~~
~~2. Patients shall be assisted to bathroom and ambulated wearing shoes or non slip socks.~~
~~3. RN family member in attendance behind curtain to assist out-patient while dressing prior to discharge.~~
~~4. Stoplight magnets and overhead laminates are not required.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11	**SUBJECT: Interpretation and Translation Services**
REVISION DATE: 10/13; 01/14; 01/15	**POLICY NUMBER: II.J**

Department Approval:	**09/16**
Clinical Policies & Procedures Committee Approval:	**~~12/15~~10/16**
Nurse Executive Council Approval:	**~~01/16~~10/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~11/16**
Professional Affairs Committee Approval:	**~~03/16~~01/17**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To outline the policy and procedure for provision of interpretation services within Tri-City Healthcare District (TCHD) for patients with limited English proficiency.

B. **DEFINITIONS:**

1. Communicatively Impaired: A communicatively impaired individual has expressive or receptive language deficits that may be present after an illness or injury. This may include individuals with: voice disorders, laryngectomy, glossectomy, cognitive disorder, or temporary disruption of the vocal cords due to intubation or medical treatment.
2. Limited English Proficiency (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.
3. Primary or Preferred Language: the language the patient wants to use to communicate with his/her provider(s).
4. Interpretation and Translation: Interpretation involves the immediate communication of meaning from one language (the source language) into another (the target language). An interpreter conveys meaning orally, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments. A translation conveys meaning from written text to written text. A sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Interpretation and translation require different skills.
5. Interpreters:
   a. Bilingual Employees: Personnel with validated competency that specifies the parameters within which the employee, in the course of providing services, may communicate directly with patients, family members, surrogate decision makers and visitors in a foreign language. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   b. Dual-Role Employees: Personnel with validated competency that specifies the parameters within which the employee may serve as interpreter in the course of providing services within their unit or in emergency situations. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.
   c. Medical/healthcare Information Interpreter: Personnel with validated competency to interpret critical medical communications including but not limited to medical care, treatment, medical decision making. **May include in-house healthcare interpreters and assessed/qualified dual role.**
   d. Service Information Interpreters: Personnel with validated competency to interpret limited topics related to critical service information.

e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.
f. Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.
g. Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.

6. Critical Medical Communications: Generally includes but not limited to:
   a. Consent and/or acknowledgement of information discussion
   b. Advance directive discussion
   c. "Do Not Resuscitate" (DNR) and discussion
   d. Explaining any diagnosis and plan for medical treatment
   e. Explaining any medical procedures, tests or surgeries
   f. Initial medication education
   g. Patient complaints
   h. Final discharge instructions
7. Critical Service Information: Generally includes but not limited to:
   a. Agreement for Services
   b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
   c. Applications to participate in a program or activity or to receive hospital benefits or services.

C. **POLICY**

1. TCHD provides qualified interpreters at no cost to patients whenever a language or communication barrier exists. Interpretation services are available on the premises or accessible by telephone or video remote interpreting (VRI) 24 hours a day, seven (7) days a week.
2. TCHD qualified interpreters will be utilized for interpretation appropriate to their level of competency.
   a. The telephone interpretation service or VRI shall be used in the absence of a TCHD qualified interpreter whenever necessary for any language.
3. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs.
   a. Patient refusal of TCHD's interpretation service must be documented in the medical record in addition to the name of the individual that the patient has selected to perform interpretation.
   b. Staff members may access a TCHD medical information interpreter if at any time they feel there is a communication barrier with the interpreter selected by the patient and may have a hospital-designated interpreter monitor the communication.
4. Documents and forms shall be either provided in the preferred language of patient/family when available or explained verbally.
5. Notices advising patients and families of availability of interpretation services, procedures for obtaining assistance and lodging complaints are displayed in public areas on the Patient Rights posters and patient handbooks.
6. Education on interpretation services shall be provided in New Employee Orientation and as needed in department/committee meetings.

. **PROCEDURE**

1. Registration
   a. Upon first encounter (registration, check-in), Access personnel shall identify the patients preferred language for discussing health care. The designation shall be documented in the electronic health record as appropriate.

i. A service information interpreter shall be utilized as needed

2. Inpatient or Outpatient Areas
   a. Assess and document patient needs and preferred methods(s) for interpretation services in the medical record and incorporate into the plan of care.
   b. Contact TCHD qualified interpreter based on the level of interpretation services (general information or critical medical communication) needed (see definitions and reference Tri-City Healthcare District qualified interpreters information on the Intranet).
   c. If a TCHD qualified interpreter is not available, contact either the facility designated telephone interpreting service (see Language Services Associates instructions on the Intranet), or facility designated video remote interpreting services (see Language Services Associates , NexTalk and Status instructions on the intranet).

E. DOCUMENTATION

1. Document the use of all interpretation/translation services, including patient selected individual for medical interpretation in the patient's medical record and include: date, interpreter's name or ID number, language, and reason for interpretation / call (i.e., "John Smith, patient's wife or "Mary Jones, Official Interpreter, or "telephone Interpreter ID # 123, Language: Korean, Reason: to discuss surgical procedure).

F. FORM/RELATED DOCUMENTS:

1. Interpretation and Translation Resources – Quick Reference & User Guides

G. REFERENCES

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. 42 CRF 124.602(c)
3. 45 CFR 84.52 (c) and (d)
4. Section 504 of Rehabilitation Act of 1973
5. Title VI of Civil Rights Act of 1964
6. Section 1259, California Health & Safety Code
7. National Standards for Culturally and Linguistic Appropriate Services (CLAS)
8. National Association for the Deaf: www.nad.org
9. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
10. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
11. Limited English Proficiency (LEP) A Federal Interagency Website (www.lep.gov).

ISSUE DATE: 9/05 **SUBJECT:** Medication Reconciliation

REVISION DATE: 6/03, 5/05, 4/09, 5/12 **POLICY NUMBER:** IV.JJ

Clinical Policies & Procedures Committee Approval:	**~~05/12~~08/16**
Nurse Executive Council Approval:	**~~05/12~~09/16**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**11/16**
Medical Executive Committee Approval:	**~~06/12~~11/16**
Professional Affairs Committee Approval:	**~~07/12~~01/17**
Board of Directors Approval:	**07/12**

A. **POLICY:**

1. Medication reconciliation is an interdisciplinary process between the patient, nurse, pharmacy, and physician designed to decrease medication Adverse Drug Events/Adverse Drug Reactions (ADE/ADR) and ensure accuracy in the list of the patient's current medications at each change in level of care or at discharge.
2. All Inpatients shall have all medications reconciled within 24 hours of admission. The final outcome of medication reconciliation is to obtain and document a complete and accurate list of the patient's current medications upon the patient's admission to the organization.
3. The most up to date, reconciled medication list is provided at all transitions of care.
4. When the patient is discharged, the reconciled list of medications is explained to the patient and the process documented.
5. The final reconciled medication list is faxed by Medical Records to the primary care provider (PCP) or other physicians that will follow up with the patient after discharge.

B. **MODIFIED MEDICATION RECONCILIATION PROCESS:**

1. Modified medication reconciliation process shall be done in areas where medications are not used, used minimally, or used for short duration including but not limited to, Emergency Department, Special Procedures, Outpatient Radiology-Imaging Contrast Studies, Outpatient Behavioral Health, Outpatient Chemotherapy, Occupational Medicine, Wound Center, Aesthetics Center, Outpatient **Specialty Services**~~Forensics~~ **and Crisis Stabilization Unit**.
   a. Home medication list must be obtained, but does not require dose, route, and frequency.
   b. Current list of home medications does not need to be provided to the patient. If the patient is confused, a list shall be provided to the family/responsible party.
      i. If there are short-term medications, the patient is provided a list with short-term medication addition(s).
   c. Complete documented medication reconciliation is required when chronic medications are prescribed, when there is a change to the patient's medications, or the patient is admitted.
   d. When a patient is discharged from the hospital at the end of an outpatient encounter, patients will be taught the importance of managing their medication information.
   e. When complete medication reconciliation is required, a list is provided to the patient and/or the primary care provider upon discharge.

C. **INPATIENT MEDICATION RECONCILIATION PROCESS:**

1. All medications shall be reconciled upon:
   a. Admission
   b. Intra-facility transfer (change in level of care)
   c. Discharge

d. The nurse shall review and complete the Medication by History screen. Every effort will be made to obtain drug name, dose, frequency and route. At a minimum, drug name will be obtained.

e. The patient's medication history may be obtained from either the patient, family members, and/or legal representative who are present at the time of admission or from Surescript if consent is obtained. The admitting nurse shall determine if they are reliable historians.
   i. If the patient, family, or legal representative is able to provide accurate data, no additional source of information is required.

f. In cases when neither the patient nor the family is considered a reliable source, alternative sources shall be located. Consider the following:
   i. Surescript database if consent obtained
   ii. Review the patient's current medical record
   iii. Discuss with family members and/or caregivers when they are available for patients who are unaccompanied on admission
   iv. Contact the patient's current pharmacy to determine or validate his/her current medications

g. Pharmacy **personnel** may assist with the medication reconciliation process as a resource.

h. The Admitting Physician/**Allied Health Professional (AHP)** is required to review, complete and reconcile, Admission Medication Reconciliation information in Cerner collected upon admission of the patients within 24 hours.

i. Once Admission Medication Reconciliation List has been completed and all medications reconciled, the complete list of the patient's medication (MAR) shall be used as the most complete and accurate medication list.

2. If new information is later obtained, the physician/**AHP** or nurse may update the Medication by History List in Cerner.

3. **Intra-Facility Transfer (Change in Level of Care):**

a. All medications will be reviewed and revised as appropriate when the patient is being transferred to the next level of care
   i. Electronic Orders:
      1) The physician/**AHP** will access the Transfer Medication Reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.
   ~~ii. Written Orders:~~
      ~~1) The physician from the SENDING unit shall print out the Transfer Reconciliation Order form and place as the first sheet under the Physician Order tab section of the patient's medical record. The physician may use this form as the actual order form or handwrite any changes in a pre-printed physician order form or the generic blank physician order form.~~
      ~~2) The nurse shall verify the physician has reviewed and signed all current orders and determined which orders shall be continued at the new level of care.~~
      ~~3) The nurse from the RECEIVING unit will process the transfer orders and scan to the Pharmacy.~~

4. **Discharge:**

a. All medications will be reviewed against HOME medications to create a final discharge mediation list
   i. Electronic Orders:
      1) The physician/**AHP** will complete the Discharge Mediation Reconciliation application in Cerner and will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
      2) Prescriptions to be completed
         a) ePrescribe – electronic prescription transmitted to the patient's pharmacy
         b) Printed on the unit and handed to the patient
         c) Handwritten on personal (physician's) prescription pad
   ~~ii. Written Orders:~~

~~1) The physician will print the Discharge Medication Reconciliation Form from Cerner and will review and reconcile each medication on the active list and home list to either be continued or not continued upon discharge and signs. This order sheet will be places as the first sheet under the Physician Order tab section of the patient's medical record.~~

~~2) The nurse shall enter these orders into the Discharge Medication Reconciliation application in Cerner and reconcile the medications.~~

~~3) Physician handwrites prescriptions on personal (physician's) prescription pad.~~

b. The nurse shall print and deliver the Patient's Discharge Instructions, which includes the reconciled medications to the patient and/or family. These can be printed in English or Spanish. Education will be provided on any new medications that are being ordered for the patient.

c. Medical Records shall **send a Transition of Care form which includes the discharge medications**~~fax the completed Clinical Summary form and Medication Patient History form~~ to the attending physician**/AHP** and consultant(s) listed in the patient's medical record the day following discharge. This final step in the medication reconciliation process ensures the physicians**/AHPs** are notified of the list of medications and other instructions given to the patient upon discharge.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/13	**SUBJECT: NEUTROPENIC PRECAUTIONS**
REVISION DATE:	~~**POLICY NUMBER: NEW**~~
Clinical Policies & Procedures Committee Approval:	~~**01/13**~~**07/16**
Nurse Executive Council Approval:	~~**04/13**~~**07/16**
Infection Control Committee Approval:	**10/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**10/16**
Professional Affairs Committee Approval:	~~**06/13**~~**01/17**
Board of Directors Approval:	**06/13**

A. **POLICY:**
1. To outline steps for preventing infections in patients with neutropenia.
2. Patients who are identified as neutropenic have the greatest risk for infection
3. Neutropenia is defined as an absolute neutrophil count [ANC] of <500 cells/mL
4. The primary nurse must educate the patient and family on ~~these~~ neutropenic precautions.

B. **PROCEDURE:**
1. If patient has been identified as having an ANC of <500 cells/mL move patient to a private room.
2. Do not place patient in a negative pressure room unless patient requires respiratory isolation for Airbo~~u~~rne Precautions per the Tricity Medical Center's infection control manual.
3. Place sign outside of the patient's room that states "please check in with the nurses' station before entering the room". Never place a sign that states "neutropenia". This is a Health Insurance Portability and Accountability Act (HIPAA) violation.
4. Do not allow staff or visitors who have symptoms of respiratory infection to visit or care for patient
5. All visitors:
   a. Must be screened for respiratory infections
   b. Must perform hand hygiene before entering the patient's room.
6. Children must be accompanied by a responsible adult (other than the patient) at all times when visiting.
   a. Only one child may visit at a time.
   b. All children must wear a mask if visiting patient.
7. Healthcare team, **patient, family and visitors** must adhere to ~~f the following~~ neutropenic precautions ~~while patient is hospitalized~~.
8. Neutropenic Precautions:
   a. **Hygiene**
      i. All healthcare team members must use standard precautions and do hand hygiene frequently when caring for neutropenic patients
      ii. Patient must wash hands frequently and ensure they are dried properly
      iii. Patient should keep their skin clean and dry at all times (bathe daily)
      iv. Patient must protect skin from cuts and burns
      v. Patient must perform frequent oral care (at least 3 - 4 times a day)
      vi. Only use an electric shaver to remove hair (no razors).
      vii. Patient's perineal area should be cleansed after voiding and bowel movement
      viii. Menstruating women should avoid tampons
      ~~viii.~~**ix. Rectal thermometers, enemas, suppositories and rectal examinations are contraindicated**
   b. **Visitors**

i. No visitors with respiratory infections
ii. Patient should avoid people with colds or contagious illness such a chicken pox, herpes zoster or influenza

c. **Environment**
i. No fresh or dried plants and flowers **in patient room**
ii. Change the water of any water containers or pitchers and denture cups daily

d. **Food/Food Preparation**
i. Patient should not eat any foods that have not either been cooked or washed properly.
ii. Patient should be placed on a neutropenic diet
iii. Food items for the patient from the cafeteria must be covered when transported to the unit for the patient
iv. Fruits and vegetables should be well washed before eating
v. No uncooked meats, seafood, and eggs
vi. Patient should not share food utensils

e. **Vaccinations**
i. Influenza and pneumonia vaccinations are recommended
ii. Patient should not receive live vaccines such as oral polio, varicella, small pox, or nasal flu vaccine.
iii. Patient should avoid contact with people who have been vaccinated with a live virus within the past 30 days

f. **Miscellaneous**
i. Refrain from providing direct care for pets or farm animals.
ii. Avoid contact with animal feces, saliva, litter box contents or barns.
iii. Do not enter or travel through, construction/renovation or where construction material/debris has been placed or where fields have recently been plowed.

~~C.~~ **RELATED DOCUMENTS:**

1. Infection Control Policy: Standard and Transmission Based Precautions

~~C.~~**D. REFERENCES:**

1. Oncology Nursing Society (**2014**~~2009~~).Chemotherapy Biotherapy Guidelines and Recommendations for Practice Third Edition.
2. Oncology Nursing Society (**2016**~~2009~~) PEP-Preventions of Infection**.**
~~2.~~**3. Infectious Diseases Society of America (IDSA) to guide clinicians in the care of patients with chemotherapy and induced neutropenia and in the management of febrile neutropenia. http://cid.oxfordjournals.org/content/52/4/e56.full.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/97	**SUBJECT:** Nursing Students in Patient Care Areas
REVISION DATE: 3/05, 4/05; 5/08; 07/09, 07/12	**POLICY NUMBER:** VIII.M

Department Approval:	10/16
Clinical Policies & Procedures Committee Approval:	~~12/12~~10/16
Nurse Executive Council Approval:	~~12/12~~10/16
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/13~~ 11/16
Professional Affairs Committee Approval:	~~02/13~~01/17
Board of Directors Approval:	02/13

A. **POLICY:**

1. Students from several professional registered nursing (RN) schools are affiliated with **Tri-City Healthcare District (TCHD)**~~TCMC~~**TCHD** Nursing Services. All RN students must be affiliated with a school that has an agreement/contract with ~~TCMC~~**TCHD**.
   a. Student affiliation agreements are maintained in the Education Department and are signed by the Chief Nurse Executive.
2. Annually, the schools make clinical requests through the San Diego Nursing Service-Education Consortium. Requested schedules for nursing students are submitted to the Education Department for coordination and approval. Finalized schedules are distributed to the clinical areas prior to the students' arrival There are two types of clinical rotations:
   a. Clinical Rotation with Instructor On Site: a group of RN nursing students in one of the four primary clinical areas: Acute Care Services, Telemetry, Behavioral Health Unit or Women's and Children's Service Mother Baby, where the clinical instructor is on site.
   b. Clinical Rotation with Instructor Off Site: a RN nursing student in a clinical rotation where the nursing student follows an assigned staff nurse for a designated number of hours determined by the school, where the clinical instructor is off site.
   c. Any change in approved clinical rotations (department, day, time) must be authorized by the ~~TCMC~~**TCHD** Academic Liaison through the Education Department.
3. The Student Orientation Record from the San Diego Nursing Service-Education Consortium with the list of students and instructors must be submitted 2 weeks before the start of the semester for background checks.
   a. Any flagged background checks will be reviewed and any action will be decided by the Director of Human Resources and the Director of Education and Clinical Informatics. The background checks must be cleared or resolved before the start of the clinical rotation.
4. Responsibility for nursing care and related duties is retained by nursing unit when students are providing care within a patient care unit.
   a. The nursing staff has the right and responsibility to intervene or prevent a student from performing any nursing activity that appears inappropriate or potentially injurious to patients.
5. The faculty and students of affiliated schools are responsible for knowing and complying with ~~TCMC~~**TCHD** Policies and Procedures.
6. The Director or designee and the ~~TCMC~~**TCHD** Academic Liaison have the option to discuss behavioral or practice issues with students and/or instructors.

7. Staff issues identified by the nursing student instructor are to be directed to the Assistant Nurse Manager (ANM) or designee of the unit.
8. All medications shall be administered under the direct supervision of the Instructor/following Patient Care Services (PCS)) Medication Administration Policy (IV.I).
   a. The staff RN may provide the direct supervision as available.
   b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the medication administration process.
   c. When removing medications from the Pyxis machine, the Instructor or staff RN will enter their access code and student may remove medications under the direct supervision of the Instructor/staff RN.
      i. Nursing Students will not be issued their own Pyxis code.
9. A skill will be performed by the student under the direct supervision of the nursing instructor until competency is validated. Certain skills may be performed by the RN nursing student without supervision once competency has been validated by the school (RN Nursing Student Skills List attachment 1).
   a. The staff RN assigned to the patient in may provide direct supervision as available once the student has demonstrated competency with the skill. The school is responsible for validating competency.
   b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the skill.

B. **CLINICAL ROTATIONS WITH INSTRUCTORS ON SITE (REQUIREMENTS):**

1. The nursing school is responsible for planning the education program and providing Nursing Services with outlined goals and objectives relating to the clinical experience. Instructors are also responsible for updating and reviewing clinical goals for each student for every unit rotation.
2. Instructor Responsibilities:
   a. Establish orientation dates for themselves and the student groups.
      i. Orientation shall include time spent on the unit to learn standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, patient assignment mechanism, call light system, daily schedules and roles of the staff and students.
   b. The instructor shall turn in all completed forms/tests for faculty and students to Academic Liaison in the Education Department. Once the required documentation is completed and turned in, ~~TCMC~~**TCHD** badges and access codes will be issued.
      i. The orientation forms/tests are available on the consortium website.
      ii. The completed forms should be returned within the first week of the ~~TCMC~~**TCHD** rotation.
      iii. Instructors/students must complete the ~~TCMC~~**TCHD** orientation annually.
      iv. Access codes shall be issued for each semester.
   c. Select students' patient assignment and post by start of shift.
      i. The ANM or designee may change assignment according to unit needs including the number of students and ~~TCMC~~**TCHD** orientees assigned to a staff RN.
      ii. Instructor is to assess needs of the unit as well as educational objectives of students prior to making patient assignments
   d. Monitor the activities of the students at all times and is present on the units to monitor students or is available to students via pager and/or cell phone.
   ~~d.~~**e.** **Ensure students comply with all policies related to protected health information (PHI).**
   ~~e.~~**f.** Assessments may only be documented by RN nursing student when performed under the direct supervision of the instructor. The instructor supervising the assessment will authenticate the documentation.
      i. Assessments performed without direct supervision may not be documented in the medical record.

ii. The staff RN assigned to that patient may provide direct supervision as available once the student has demonstrated competency with the skill. If the staff RN provides supervision, they will authenticate the documentation.

~~f.~~**g.** The instructor shall review student documentation including but not limited to:
- i. Medication administration
- ii. Vital Signs
- iii. Plan of care
- iv. Clinical notes
- v. The staff RN assigned to the patient may review the student documentation as available.

~~g.~~**h.** Teach and supervise student education and actions while on the unit.

~~h.~~**i.** Communicate expectations of student's performance.

~~i.~~**j.** Evaluate the student's clinical competency prior to arrival on the floor and also during performance of patient care skills.

~~j.~~**k.** Assume final responsibility for management and evaluation of students.

3. Student Responsibilities:
   a. Report to work at a specified time to receive report on their assigned patients from the primary nurse.
      i. Perform nursing care according to ~~TCMC~~**TCHD** policies and procedures. Care delivery must be under the direct supervision of the Instructor or staff RN according to attachment 1.
      ii. Students are not to leave floor/unit without reporting to primary nurse.
      iii. Ensure documentation is reviewed and authenticated by instructor/staff RN.
      iv. Students shall not be excused until Intake and Output and charting is reviewed by the Instructor and verbal report is given to the primary nurse.
      v. All unfinished work is to be reported to the primary nurse.
   b. Communicate all pertinent information including changes in patient status, problems, concerns, and questions or learning needs to patient's primary RN.
   c. Work with all health care team members in an effective/professional manner.
   d. Review paper and electronic chart prior to the start of patient care and throughout the shift.
4. Staff RN Responsibilities:
   a. Function as role models and are responsible for the nursing care given to the patients/families.
   b. Facilitate the student learning experience as available.

C. **CLINICAL ROTATIONS WITH INSTRUCTORS OFF SITE (ADDITIONAL REQUIREMENTS):**
1. Clinical Instructor
   a. Submit the request for preceptors to the ~~TCMC~~**TCHD** Academic Liaison prior to the start of the rotation.
   b. Ensure students are oriented to ~~TCMC~~**TCHD** and forms/tests for faculty and students are completed and turned in within the first week of the rotation.
   c. Provide to the department goals of the rotation and hours required.
   ~~c.~~**d.** Ensure students have access to clinical application including but not limited to Cerner, capillary blood glucose meter and Supply Pyxis.
   ~~d.~~**e.** Manage any concerns/problems with students including conflicts with schedule
2. ~~TCMC~~**TCHD** Academic Liaison Responsibilities
   a. Collaborate with the Clinical Educator/Manager to assign students to a specific department.
   b. Provide to the department ~~goals of the rotation including~~ dates of the rotation and **minimum** hours required.
3. Clinical Educator/Manager Responsibilities
   a. Identify staff RN and provide the name of staff RN to facilitate scheduling the RN nursing student with the staff RN

i. The instructor is responsible for managing any concerns/problems including conflicts with schedules.

4. RN Nursing Students Responsibilities:
   a. Follow designated staff RN's schedule.
      i. If staff RN is not available (Hospital Requested Time Off or illness) the nursing unit is responsible for assigning an alternative staff RN for that shift.
      ii. If the student unable to report for an assigned shift, they must notify the nursing unit. The student will make arrangements with the nursing unit to make up the shift.
   b. Report to nursing unit with academic skills checklist and clinical goals/objectives for each shift. The student may only perform skills for which they have demonstrated competency as validated by the school.
   c. Discuss any schedule conflicts with Clinical Instructor.
5. Staff RN Responsibilities:
   a. Ensure the student functions appropriately within their scope of practice and in accordance ~~TCMC~~**TCHD** policies and procedures.
   b. Review the skills the RN nursing student has demonstrated competency which have been validated by the school. The staff RN is not responsible for teaching new skills.
   c. Observe assessments performed by the RN nursing student. The staff RN will authenticate the assessment documentation.
   d. Review student documentation including but not limited to:
      i. Medication administration
      ii. Vital Signs
      iii. Plan of care
      iv. Clinical notes
   e. Provide feedback to the Instructor on the student's performance during the rotation.

RN Nursing Student Skills List

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
ADLs	Yes		Yes
Ambulation/Transfer (Fall Risk Procedure)	Yes		Yes
Assessments	Yes	Yes	
Bath	Yes		Yes
Blood Product Administration	**NO**		
CAPD, Peritoneal Dialysis Administration	**NO**		
Capillary Blood Glucose Testing	Yes		Yes
ECG Monitoring Electrode Application	Yes		Yes
Endotracheal Suctioning Deep	Yes	Yes	
Enema Administer Non-Medicated Solution	Yes	Yes	
Feeding Tube (weighted/non-weighted) Discontinuation	Yes	Yes	
Feeding Tube (weighted/non-weighted) Insertion	Yes	Yes	
Feeding Tube (weighted/non-weighted) Irrigation	Yes	Yes	
Gastrostomy Tube Care	Yes	Yes	
Hand Off Communication	Yes		Yes
Hygiene (personal) Administration	Yes		Yes
Intake/Output	Yes		Yes
Isolation Precautions	Yes		Yes
IV Central Venous Access Dressing Change	Yes	Yes	
IV Peripheral Access/Venipuncture Insertion	Yes	Yes	
IV Peripheral Access Discontinuation	Yes	Yes	
Pulse Oximetry Monitoring	Yes		Yes
Epidural Infusions Maintain/Discontinue	**NO**		
Meal - Assist with Feeding (Aspiration Precautions)	Yes		Yes
Medication Administration - Chemotherapy	**NO**		
Medication Administration Investigational/Experimental Drugs	**NO**		
Medication Administration – Gastrostomy Tube	Yes	Yes	
Medications Administration - Eye	Yes	Yes	
Medications Administration - Intramuscular (IM)	Yes	Yes	
Medications Administration - Oral	Yes	Yes	
Medications Administration - Subcutaneous	Yes	Yes	

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Medications Administration IV Peripheral Push*	Yes	Yes	
Medications Administration IV Central Venous Access	Yes	Yes	
Medications Administration IV Peripheral - Infusion pump	Yes	Yes	
Nasogastric Tube Discontinuation	Yes	Yes	
Nasogastric Tube Insertion	Yes	Yes	
Nasogastric Tube Irrigation/Care	Yes	Yes	
Neonatal – Bath	Yes		Yes
Neonatal – Developmental Care	Yes	Yes	
Neonatal – Diaper Change	Yes	Yes	
Neonatal – Heel Sticks	Yes	Yes	
Neonatal - Medication Administration Eyes	Yes	Yes	
Neonatal - Medication Administration IM	Yes	Yes	
Neonatal – Feeding Breast & Bottle	Yes	Yes	
Neonatal – Skin Care	Yes	Yes	
Neonatal – Transcutaneous Bilirubin (TCB) screening	Yes	Yes	
Neonatal – Universal Saturation Screening	Yes	Yes	
Oral gastric tubes insertion/irrigation/discontinuation	**NO**		
Ostomy maintenance	Yes	Yes	
Ostomy irrigation	**NO**		
Rectal Tube Insertion/irrigation/discontinuation	**NO**		
Skin Care Pressure Ulcer Precautions	Yes		Yes
Skin Care Simple Dressing Change	Yes	Yes	
Specimen Collect urine / stool / expectorated sputum	Yes	Yes	
Standardized Procedure Initiation	**NO**		
Staple Removal	Yes	Yes	
Sterile Procedures / Surgical Skin Preparation (excluding Surgical Area)	Yes	Yes	
Suprapubic catheter Irrigation	**NO**		
Surgical drains (penrose, constavac, JP) removal	Yes	Yes	
Telephone/Verbal Orders	**NO**		
Tracheotomy care	Yes	Yes	
Urinary drainage catheters (Foley) Care	Yes		Yes

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Urinary drainage catheters (Foley) Discontinuation	Yes	Yes	
Urinary drainage catheters (Foley) Insertion	Yes	Yes	
Vital signs (Temp, BP, HR, RR SpO_2, Pain)	Yes		Yes

* Medications Administration IV Peripheral Push: antidysrthmics, intropes and medications for cardiac rhythm control may not be administered by RN nursing students.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Surgical Skin Stapling

REVISION DATE:

Clinical Policies & Procedures Committee Approval:	01/16
Nurse Executive Council Approval:	01/16
Operating Room Committee Approval:	09/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	10/16
Professional Affairs Committee Approval:	01/17
Board of Directors Approval:	

A. POLICY:

1. Surgical Technologists and Registered Nurses may ~~fire~~ utilize an automatic skin staple gun under the direct supervision of the ~~Licensed Independent Practitioner (LIP)~~physician/Allied Health Professional (AHP) for the purpose of skin closure.
   a. Deep tissue stapling is not allowed.

B. PROCEUDRE:

1. Under the direction of the ~~LIP~~physician/AHP, lightly position the automatic skin stapler over the approximated skin edges at the diesired position.
   a. It is not necessary to press the stapler into the skin to get a proper placement; lightly touch the skin.
2. Center the staples over the incision line using the locating arrow or guideline on the stapler.
3. Press the stapler anvil to deploy the staples as the ~~LIP~~physician/AHP approximates the skin edges.
4. Place staples approximately ¼" apart, as directed by the physician/AHP~~LIP~~.

C. REFRENCES:

1. Rothrock, J. (200~~7~~14). Alexander's Care of the Patient in Surgery, 13~~5~~th Edition.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 7/93

SUBJECT: SWALLOWING, FOOD AND NUTRITION CONSIDERATIONS FOR PATIENTS WITH ORO-PHARYNGEAL DYSPHAGIA

REVISION DATE: 6/03, 8/05, 7/07, 5/10, 3/13

POLICY NUMBER: IV.AA.2

Department Approval:	08/16
Clinical Policies & Procedures Committee Approval:	~~03/13~~09/16
Nurse Executive Council Approval:	~~03/13~~09/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/13~~10/16
Professional Affairs Committee Approval:	~~05/13~~01/17
Board of Directors Approval:	05/13

A. **POLICY:**

~~A. When thick liquids, thickened liquids, or no thin liquids, are ordered for patients, the unit secretary, nurse, dietician or speech pathologist shall enter diet order into the computer and include ""no thin liquids" in Dietary comments section.~~

~~B.~~**1.** An order for thick liquids, thickened liquids, or no thin liquids shall be interpreted by Food and Nutrition Services staff as meals with no thin liquids until further clarification or orders are received from physician.

~~1.~~**a.** When an order for no thin liquids is received, meals sent to the patient shall be without thin liquids. Thin liquids are defined as: water, coffee, tea, iced tea, milk, all fruit juices (except nectars), and broth, broth-based soups, soft drinks, Boost, hot chocolate and milkshakes.

~~2.~~**b.** Thickened milk and thickened juices are available and may be added to the menu.

~~3.~~**c.** Thick liquids shall be offered. These include nectar, vegetable juices, blenderized or thick cream soups, eggnog, and other pre-thickened liquids. Buttermilk shall be sent if requested.

~~4.~~**d.** Foods of mixed consistencies where one consistency is thin liquid (i.e. fruit cocktail, dry cereal with milk, vegetable soup, and pineapple chunks) shall not be included unless otherwise ordered by the physician.

~~5.~~**e.** In cases when speech therapy is involved in the patient's care, the speech pathologist may assess the patient's tolerance of liquids and may consult with the dietician, as appropriate.

~~a.~~**i.** Recommendations for changes to diet will be made to the physician.

~~6.~~**f.** The dietitian shall assess the patient's status per routine assessment and evaluation. The dietitian shall update the diet order in the electronic health record as appropriate.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 11/94 **SUBJECT: DECORATIVE MATERIAL**

REVISION DATE: 03/00; 02/06; 01/09; 09/10 **POLICY NUMBER:** 8610-248

Department Approval:	**10/16**
Administrative Policies & Procedures Committee Approval:	**~~10/10~~10/16**
~~Operations Team Committee Approval:~~	**~~11/10~~**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~01/11~~01/17**
Board of Directors Approval:	**01/11**

A. **PURPOSE:**

1. The purpose of this policy is to provide for the safety of patients, staff and visitors of the Medical Center by setting forth guidelines for the use of decorative materials within the Medical Center. This policy is in accordance with local and state Fire Codes.

B. **POLICY:**

1. Stairways, corridors, and exit ways shall not be obstructed and decorations shall not be hung in a way as to obstruct exits, exit lights, fire sprinkler heads, fire alarm pull stations, hose cabinets, or fire extinguishers.
2. Decorative materials shall not be hung from the sprinkler heads.
3. All decorative materials need to be approved by the Director of Facilities or the **Director of** Safety/**Environment of Care** Officer.
4. Use only materials labeled nonflammable or flame-retardant in your displays (includes artificial trees).
   a. Have documentation (i.e., package labeling) to this effect on file in your department for Fire Department review if necessary.
5. Live trees are prohibited.
6. The Fire Marshall permits electric lights only in the main lobby under strictly controlled conditions. All other areas may use only battery-operated lights.

SUBJECT: Emergency Operations Plan

ISSUE DATE: 06/08 **POLICY NUMBER:** 4001
REVIEW DATE(S): 06/11
REVISION DATE(S): 05/15

Department Approval Date(s):	**05/15, 06/16**
Environmental Health and Safety Committee Approval Dates(s):	**06/15, 10/16**
Medical Executive Committee Approval Dates(s):	**N/A**
Professional Affairs Committee Approval Date(s):	**~~06/15~~01/17**
Board of Directors Approval Date(s):	**06/15**

A. **SCOPE OF SERVICES**:

1. The scope of Tri City ~~Medical Center's~~**Hospital District (TCHD)** Emergency Operations Plan (EOP) is to provide a program that ensures effective mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care. The medical center has developed an "all hazards" approach that supports a level of preparedness sufficient to address a wide range of emergencies regardless of cause. The Emergency Operations Plan and associated Emergency Management Program extends to all inpatient and outpatient line programs, ancillary services, support services and facilities including patient care, business occupancies and temporary alternate care sites of Tri City Medical Center. The plan also affects all staff, volunteers, contract staff, medical staff and associates including contracted services of Tri City ~~Medical Center~~ **Hospital District**.

B. **OBJECTIVE**:

1. The objective of the Emergency Operations Plan is to effectively prepare for, manage an emergency situation and restore the facility to the same operational capabilities as pre-emergency levels.
2. Six (6) critical areas of emergency response shall be managed in order to assess the medical center's needs and prepare personnel to respond to incidents. The six critical areas are:
   a. Communication
   b. Resources and Assets
   c. Safety and Security
   d. Personnel Responsibilities
   e. Utilities Management
   f. Patient Clinical and Support Activities

C. **OBJECTIVES:**

1. The objectives of the Emergency Operations Plan will include the following:
   a. Identifying procedures to prepare and respond to potential disasters or emergencies.
   b. Provide education to personnel on the elements of the Emergency Operations Plan.
   c. Establish and implement procedures in response to an assortment of disaster and emergency situations.
   d. Identify alternate sources for supplies and services in the event of a disaster or emergency through establishing mutual-aid agreements with neighboring hospitals and/or healthcare systems; public health departments; hazardous materials response teams; local fire department; local police department; area pharmacies; medical supply

vendors.

e. Identify recovery strategies and actions to be activated in the event of a disaster or emergency situation.

D. **RESPONSIBILITY**:

1. The Safety Officer, in conjunction with the Environmental Health and Safety Committee is responsible for developing, implementing and monitoring all aspects of the Emergency Operations Plan, including the hazard vulnerability analysis, mitigation, preparedness, response and recovery.
   a. The Safety Officer shall also track National Incident Management System (NIMS) implementation.
   b. The Safety Officer will have a working knowledge of emergency management, the medical centers operations (daily/emergency) and the Hospital Incident Command Center operations.
   c. It will be the responsibility of the medical centers leaders, as well as, medical personnel to actively participate in the organizations Emergency Operations Plan.
   d. The Emergency Operations Plan shall be developed in coordination with local community agencies. The medical center shall communicate its needs and vulnerabilities to community emergency response agencies and identify the capabilities of the community in meeting the needs of the medical center.

E. **SPECIFIC PROCEDURES IN RESPONSE TO A VARIETY OF EMERGENCIES BASED ON A HAZARD VULNERABILITY ANALYSIS PERFORMED BY THE MEDICAL CENTER**.

1. The medical center has developed specific procedures in response to potential disasters and emergencies that may occur. Additionally, the medical center will create a Hazard Vulnerability Analysis (HVA) to identify areas of vulnerability and to undertake provisions to lessen the severity and/or impact of a disaster or emergency that could affect the services provided by the medical center.
2. The HVA is evaluated on an annual basis and input from the local fire department and community agencies and will be obtained to assure the medical center is aware of hazards in the community to which an emergency response may be required.
3. The medical center has developed a Utilities Disruption Matrix designed to provide available operational hours prior to departmental shut down or commencing of evacuation procedures. The Utilities Disruption Matrix is based on the medical center having the capabilities of operating self-sufficiently for up to *96 hours* without the assistance of external agencies or resources.
4. For each emergency identified in the medical center's HVA as a high risk, the following shall be defined:
   a. Mitigation activities that are designed to reduce the risk of potential damage due to an emergency situation.
   b. Preparedness activities that organize and mobilize essential resources.
   c. Response strategies and actions to be activated during an emergency situation.
   d. Recovery strategies/actions that will help restore the systems that are critical to resuming normal operations of the medical center.
5. Will maintain a documented inventory of on-site assets and resources that will be needed during an emergency. At a minimum, this inventory should include:
   a. Personal Protection Equipment (PPE)
   b. Water
   c. Fuel
   d. Staffing
   e. Linen
   f. Cleaning Supplies
   g. Food

h. Medical/Surgical Resources
i. Pharmaceutical Resources

6. The inventory of assets and resources shall be evaluated on an annual basis or as needed.
7. Methods shall be in place for the monitoring of the inventory of assets and resources during an emergency situation.

F. **DEFINE AND INTEGRATE THE MEDICAL CENTERS ROLE WITH THE COMMUNITYWIDE EMERGENCY OPERATIONS EFFORTS TO PROMOTE INTER-OPERABILITY BETWEEN THE FACILITY AND THE COMMUNITY:**

1. The Emergency Operations Plan shall be tested and exercises shall be developed based on the medical center's top scoring emergency situations within the Hazard Vulnerability Analysis. The exercise shall validate the effectiveness of the Emergency Operations Plan and will identify opportunities to improve.
2. The Emergency Operations Plan shall be tested and exercised a minimum of two (2) times per year, either in response to an actual emergency or in a planned exercise.
3. Only one (1) exercise per year shall include an influx of volunteer or simulated patients.
4. At least one (1) exercise per year shall be evaluated to see how effectively the hospital performs when the medical center cannot be supported by the local community for up to 96 hours. (Tabletop sessions are acceptable to meet the community portion of this exercise).
5. If applicable, the medical center will participate in at least one (1) communitywide exercise annually that is relevant to the priority of emergencies defined in the hazard vulnerability analysis. (Tabletop sessions are acceptable to meet the community portion of this exercise).
6. The Director of Safety (Safety Officer) is identified as the designee whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.
7. The medical center cooperates with all local, county and state emergency management exercises. The Safety Officer is a member of the countywide emergency management system and coordinates with other agencies on any large scale exercises. San Diego Department of Public Health and Human Services Agency/EMS and Statewide Disaster planning efforts, coordinate with local police, fire and ambulance services in conjunction with acute care facilities.

G. **COMMAND STRUCTURE**:

1. The command structure utilized by the medical center in coordination with the communitywide structure will be the Hospital Incident Command System (HICS).

H. **INITIATING THE PLAN, INCLUDING DESCRIPTION OF PLAN ACTIVATION**:

1. The Emergency Operations Plan will be activated when it has been determined that a disaster or emergency situation has occurred or has the potential of occurring.
2. The Joint Commission's definition of an emergency:
   a. *"a natural or man-made event that significantly disrupts the environment of care; that significantly disrupts care and treatment; or that results in sudden, significantly changed or increased demands for the organizations services. Some emergencies are called 'disasters' or 'potential injury creating events'."*
3. When the facility is notified of an emergency situation, the person receiving notification will immediately notify the Chief Executive Officer or his/her designee of the situation whether it be an external or internal emergency. The Nursing Administrative Supervisor will respond to the site of an internal emergency and report back to the Chief Executive Officer or his/her designee, the status of the situation.
4. The Chief Executive Officer or his/her designee will evaluate the emergency situation to determine whether the Emergency Operations Plan will be activated. If the Emergency Operations Plan is to be activated, the Chief Executive Officer or his/her designee will notify the Switchboard Operator to announce Code Orange External/Internal overhead.
5. The Chief Executive Officer or appointed designee will assume responsibility of the Hospital

Incident Command center and activate the appropriate positions noted on the Incident Management Team Chart as deemed necessary for the occurrence:

a. Until the Incident Command System is in place, the Chief Executive Officer or his/her designee will determine if the Labor Pool will be opened depending on the size of the emergency situation. If the Labor Pool is not opened, the Nursing Administrative Supervisor may assign additional assistance to the Emergency Area as needed. Additional personnel will be called in as needed via the staff call back system.

b. The Nursing Administrative Supervisor will notify additional outside agencies that may need to assist the medical center in the event of an internal emergency (*i.e. fire department, police department or other agencies).*

6. The recovery phase will be initiated after the emergency situation is over and the medical center has been evaluated. The recovery phase of the plan is to be initiated by the Chief Executive Officer or his/her designee.

I. **COMMUNICATION:**

1. Notification of External Authorities:
   a. The medical center shall have a communications system in place, including two-way radio equipment and operators who are familiar with the equipment's operation.
   b. The medical center will provide for alternate communication methods in the event of a failure. Two-way radio equipment and cell phones shall be available in the event of an emergency. In the event that cell phones are not working, microwave communications, satellite phones, ham radios or portable 800 MHZ radios may be used.
2. The Safety Officer will approve media access to the facility, with only the Public Information Officer (PIO) interacting with the media.
3. A medical record system will be used to meet the minimum requirements of emergency management operations.

J. **PERSONNEL RESPONSIBILITIES**:

1. Notification of Personnel When Emergency Operations Plan is initiated:
   a. In an emergency situation which is so wide spread to be considered an emergency and/or involving mass casualties, all medical center personnel, regardless of position, are expected to report to the medical center as soon as it is feasible to travel. Each department director maintains a current callback list of all personnel assigned to their department. Once the Emergency Operations Plan has been activated, the department director in cooperation with Human Resources will assign a staff member to initiate the call back list.
   b. In the event there are excess personnel, the Hospital Command Center will communicate with department directors regarding rescheduling of personnel future needs. The medical staff will report to the Chief of Medical Staff or Medical Specialist Officer for their assignments.
2. Alternate Roles and Responsibilities of Personnel during Emergencies:
   a. Personnel may not be assigned to their regular duties. Personnel will be asked to perform various jobs which will be considered vital to the effective operation of the hospital during the emergency situation. Personnel will be assigned duties based on the needs of the medical center. If personnel are not needed in their perspective units/departments, they will be sent to the Labor Pool for assignment.
3. Identification of Personnel in Emergencies:
   a. Personnel on duty during activation of the Emergency Operations Plan will be identified by their picture identification name badge, which is mandated to be worn at all times while on duty.
   b. Only persons wearing proper identification or possess valid credentials shall be allowed entrance into the medical center during an emergency situation.
4. Personnel Activities and Support:
   a. The medical center has made provisions for staff support that can be implemented in

the event of a communitywide emergency. Such provisions may include but not limited to:

i. Temporary housing/lodging needs.
ii. Transportation needs.
iii. Family support needs, as necessary (including short term child care)
iv. Incident stress debriefing and counseling.

5. Orientation and Training:
   a. Personnel will attend orientation upon hire and annually thereafter, reviewing their specific roles and responsibilities during an emergency/disaster situation.
   b. In-service education will be given to the specific staff on the backup communication system and obtaining supplies/equipment in the event of an emergency/disaster situation.
   c. The Safety Officer or designee is responsible for in-servicing personnel to the Emergency Operations Plan.
   d. The department directors are responsible for in-servicing their department personnel on the department specific responsibilities during an emergency/disaster situation.

K. **EMERGENCY CREDENTIALING OF CAREGIVERS**:

1. To provide a mechanism for emergency credentialing and granting privileges to volunteer/non-staff licensed independent practitioners in the event of a disaster.
2. The Chief Executive Officer or Chief of Staff or their designee(s), may grant emergency privileges upon presentation of a valid picture ID (issued by a state, federal or regulatory agency) e.g., driver's license or passport and at least one of the following:
   a. A current license to practice or primary source of verification of the license.
   b. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
   c. Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
   d. Presentation by current facility or medical staff member with personal knowledge regarding practitioner's identity.
3. Verification of Information:
   a. Verification of the required information shall be done by the Medical Staff Office or designee as soon as feasible. A record of this information will be retained in the Medical Staff Office.
4. Conditions of Emergency Privileges:
   a. The emergency designee must practice under the direction and supervision of an existing member of the Tri City ~~Medical Center~~ **Hospital District**.

L. **RESOURCES AND ASSETS**:

1. The medical center keeps a documented inventory of assets it has on site that would be needed in the event of an emergency or disaster situation. At a minimum, the inventory should include:
   a. Linen
   b. Cleaning Supplies
   c. Personal Protective Equipment (PPE)
   d. Water
   e. Food
   f. Fuel
   g. Staffing
   h. Medical Resources and Assets
   i. Surgical Resources and Assets
   j. Pharmaceutical Resources and Assets
2. Methods are established to monitor quantities of assets and resources during an emergency or

disaster situation.

3. Arrange for emergency/disaster supporting services to be performed by local businesses, utility companies, government agencies and individuals. Emergency/ disaster supporting services may include:
   a. Transportation
   b. Communications
   c. Traffic Control
   d. Food Supplies
   e. Utility Maintenance
   f. Medical Supplies
4. These arrangements must be coordinated with the assistance of the Safety Officer, San Diego Department of Public Health or the local Office of Emergency Services (OES) whenever possible.
5. The medical center shall estimate its emergency needs for each kind of support and when feasible arrange to have supporting supplies, equipment and manpower pre-designated for medical center use.
6. Essential supplies, pharmaceuticals, medical supplies, equipment, food, water, linen, cleaning supplies and utilities shall be provided to meet shelter requirements for up to *96 hours* when the medical center cannot be supported by the community. Procedures are in place for the procurement of additional supplies in an emergency.
7. In the event that the medical center cannot be supported by the local community for at least *96 hours,* the Chief Executive Officer/Incident Commander, Incident Command Staff and in consultation with community leaders, will evaluate the following options and implement those options that best serve the medical center and community:
   a. Conservation of Resources
   b. Curtailment of Services
   c. Supplementing of resources from outside of the local community
   d. Staged Evacuation
   e. Total Evacuation

M. **SAFETY AND SECURITY**:

1. Efficient traffic flow must be established:
   a. Prepare floor plans which designate areas for specific patient care functions and ensure that personnel are familiar with these plans.
   b. Prepare and have available traffic control tools to show external and internal routing of casualties and other traffic.
   c. Assign and train volunteers to perform traffic control and security functions.
2. At the time the Emergency Operations Plan is activated, the Security Department personnel will be responsible for locking all exits and entrances with the exception of the ambulance entrance which will be manned. The Security Staff shall maintain control of entry and egress from the facility. Personnel of the medical center are required to wear badges identifying them as personnel. Only persons with proper identification shall be admitted to the medical center during an emergency situation.
3. Radioactive or Chemical Isolation and Decontamination:
   a. There is a designated decontamination room with separate ventilation system or ventilation shut off available for radioactive or chemical isolation and decontamination. Staff is trained in the response to radiological, biological, chemical or hazardous material contamination.
   b. Arrange with a local or State Emergency Management Agency Director (if applicable) for the training of staff who would perform the radiological monitoring of casualties and hospital areas and the acquisition of necessary radiological monitoring equipment. This equipment shall be stored in the medical center as part of its essential emergency supply equipment.

N. **UTILITIES MANAGEMENT:**

1. The medical center will provide for alternative sources of essential utilities, including:
   a. An emergency source of electrical power capable of operating all essential electrical equipment and plan for failure of back-up generators
   b. An alternate source for medical gas and vacuum delivery
   c. An alternate means of waste disposal in the vent of sewage system failure
   d. Sufficient fuel to last for at least *96 hours* of expanded operation

O. **PATIENT CLINICAL AND SUPPORT ACTIVITIES**:

1. Management of Patients during Emergencies (i.e. Scheduling, Modification or Discontinuation of Services, Control of Patient Information and Patient Transportation)
   a. Upon activation of the Emergency Operations Plan, normal admission requirements will be modified. Initially, admissions to the medical center will be limited to those whose survival depends upon services obtainable only through medical care.
   b. Outpatient care will be restricted to those whose lives may be ultimately depending upon the present expenditure of medical supplies and health manpower time.
2. All elective admissions and procedures will be canceled, including elective surgery, no emergent outpatient and transferring patients who are stable to be discharged.
   a. Patients may be transferred to other facilities so those emergency victims may be accommodated.
   b. Individuals may be redirected or relocated for a Medical Screening Exam in the event that the Emergency Operations Plan has been activated. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
   c. In the event the Emergency Operations Plan is activated, persons may be transferred prior to being stabilized, if, based upon the circumstances of the emergency the medical center is unable to provide proper care or treatment of services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).

P. **EVACUATION OF THE FACILITY:**

1. When an emergency situation arises requiring evacuation of patients from threatened or affected areas, the safety of lives at Tri City ~~Medical Center~~ **Hospital District** is the primary concern. Authority to order an evacuation is vested only with the Chief Executive Officer, his/her designees, or the Safety Officer. Patients shall be evacuated to an area of safety by whatever means are available. Formal agreements are in place with ambulance services and alternate care sites to transfer patients as necessary.
2. All personnel have been trained in evacuation procedures. Evacuation routes are posted throughout the medical center.
3. Relocation to alternate health facility or place of safety (i.e., churches, schools)
   a. Prepare maps of routes to relocation site
   b. Confirm periodically the availability of the relocation site
   c. Establish lists of supplies and equipment, by priority, to be relocated
   d. Arrange adequate transportation for evacuation and relocation
4. Establishing an Alternate Care Site When the Environment Cannot Support Adequate Patient Care
5. Formal agreements should be in place so that patients may be transferred to a facility that can provide adequate patient care. The Liaison Officer will be responsible for the inter-facility communication between the medical center and the designated alternative care site, and for retaining records of which patients were transferred to and/or from an alternative care site. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If an medical equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that equipment may be retrieved during the recovery phase post emergency. The following agreements are in place:

a. Ambulance contract agreements for transfer of patients between facilities
b. Transfer agreements will be made between neighboring facilities
c. Emergency acquisitions of medical supplies, pharmaceuticals, food, equipment, water, linen, emergency repair services, etc

Q. **CONTINUING AND/OR RE-ESTABLISHING OPERATIONS FOLLOWING AN EMERGENCY**:

1. The medical center has mechanisms in place to restore the operational capabilities of the facility to pre-emergency levels. Once the emergency is over, the Engineering Department, including the Director of Facilities, Safety Officer, Risk Manager and other administration representatives, will begin assessing the damage to the facility and the environmental concerns to determine whether the medical center can safely provide medical care to the community and proved a safe environment for patients, personnel and visitors.
   a. Picture and/or videos will be taken of all damages to the facility's buildings, grounds, equipment, etc., including all off campus facilities.
   b. Architects, building inspectors and structural engineers may be called in to determine if the buildings are safe for occupancy.
   c. All potential environmental concerns will be evaluated for proper function, i.e., hazardous waste, fuel tanks, to ensure there is no leakage into the local sewer or water system or any other impact on other environmental concerns.
   d. Ensure personnel support programs have been instituted, i.e., crisis counseling, flexible work hours, cash advances, day care, particularly if your personnel and the medical center have been directly impacted by the emergency.
   e. Clear debris and secure unsafe buildings as necessary.
   f. Restore internal and external communication devices
   g. Inventory equipment and supplies for damage and determine if additional supplies need to be obtained from suppliers. Picture/videos will be taken of all damaged supplies and equipment for insurance purposes. Damaged supplies and equipment will be retained until approval is received from insurance providers for disposal.
2. Notify the community through local media services regarding the services the medical center will be providing and the location they will be provided in the event that services are moved off-campus.
   a. Notify the medical center's insurance provider and contact third-party expert to prepare the claim.
   b. Ensure records and data have been protected and restore information as necessary from backup tapes.
   c. Keep detailed records.
3. A proactive process shall be developed and implemented to seek other federal funding to support preparedness that takes advantage of developing interoperability training with local and regional multi-disciplinary partners.

R. **PERFORMANCE STANDARDS**:

1. There is a planned, systematic, interdisciplinary approach to process design and performance measurement analysis and improvement related to organization wide safety. The Environmental Health and Safety Committee will develop and establish performance measures and related outcomes in a collaborative fashion, based on those priority issues known to be associated with the healthcare environment. Performance measures and outcomes will be prioritized based upon high risk; high volume, problem prone situations and potential or actual sentinel event related occurrences. Criteria for performance improvement measurement and outcome indicator selection will be based on the following:
   a. The measure can identify the events it was intended to identify
   b. The measurement has a documented numerator and denominator statement or description of the population to which the measure is applicable.
   c. The measure has defined data elements and allowable values
   d. The measure can detect changes in performance over time

e. The measure allows for comparison over time within the organization or between the organization and other entities.
f. The data intended for collection is available.
g. Results can be reported in a way that is useful to the organization and other interested stakeholders.

S. **NIMS PREPAREDNESS FUNDING**:

1. Tri City ~~Medical Center~~ **Hospital District** shall establish a working relationship with State and San Diego County Department of Health and Human Services Agency/EMS and state associations to identify activities to obtain and appropriately allocate preparedness funding.
2. The Environmental Health and Safety Committee on an on-going basis monitors performance regarding actual or potential risk related to one or more of the following:
   a. Personnel knowledge and skills
   b. Level of personnel participation
   c. Monitoring and inspection activities
   d. Emergency and incident reporting
   e. Inspection, preventative maintenance and testing of safety equipment
   f. Other performance measures and outcomes will be established by the Environmental Health and Safety Committee based on the criterion listed above. Data sources, frequency of data collection, individual(s) responsible for data collection, aggregation and reporting will be determined by the Environmental Health and Safety Committee.
3. To identify opportunities for improvement/corrective action, the Environmental Health and Safety Committee will follow the organization's improvement methodology. The basic steps to this model will consistently be followed and include planning, designing, measuring, analyzing/assessing, improving and evaluating effectiveness. Should the Environmental Health and Safety Committee feel a team approach is necessary for performance and process improvement to occur, the Environmental Health and Safety Committee will follow the organization's performance improvement guidelines for improvement team member selection.
4. Determination of team necessity will be based on those priority issues listed (high-risk, volume and problem prone situations and sentinel event occurrence). The Environmental Health and Safety Committee will review the necessity of team development, requesting primarily, team participation only in those instances where it is felt the Environmental Health and Safety Committee's contributions toward improvement would be limited (due to specialty, limited scope and/or knowledge of the subject matter). Should team development be deemed necessary, team members will be selected on the basis of their knowledge of the subject identified for improvement and those individuals who are "closest" to the subject identified. The team will be interdisciplinary, as appropriate to the subject to be improved.
5. Performance Improvement monitoring and outcome activities will be presented to the Environmental Health and Safety Committee by the Safety Officer at least on a quarterly basis, with a report of performance outcome to the Quality Assurance Performance Improvement (QAPI) Committee.

T. **ANNUAL EVALUATION OF THE EMERGENCY OPERATIONS PLAN OBJECTIVES, SCOPE, PERFORMANCE AND EFFECTIVENESS**:

1. The annual evaluation of the Emergency Operations Plan will include a review of the scope according to Joint Commission standards and NIMS requirements to evaluate the degree in which the program meets accreditation standards, NIMS requirements and the current risk assessment of the medical center.
   a. A comparison of the expectations and actual results of the program will be evaluated to determine if the goals and objectives of the program were met.
   b. The overall performance of the program will be reviewed by evaluating the results of performance improvement outcomes. The overall effectiveness of the program will be evaluated by determining the degree that expectations were met.
   c. The Emergency Operations Plan shall be revised and updated based on the annual

evaluation of the Emergency Operations Program, including the Hazard Vulnerability Analysis.

2. The performance and effectiveness of the Emergency Operations Plan shall be reviewed by the Environmental Health and Safety Committee, the QAPI Committee, Administration and reported to the Board of Directors as well.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Equipment Repair~~ ~~Policy Number: 2008 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Equipment Repair

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval Date(s): **7/16**
Environmental Health and Safety Committee Approval Date(s): **7/16**
Professional Affairs Committee Approval Date(s): **01/17**
Board of Directors Approval Date(s):

A. **PURPOSE**
1. To outline the procedure by which damaged or malfunctioning equipment will be repaired.

B. **GENERAL INFORMATION:**
1. CMMS- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

C. **PROCEDURE:**
1. In response to a work order submitted ~~by a user department~~, the **E**engineer inspects damaged or malfunctioning equipment to determine what repairs or adjustments are needed, if any.
2. If the **Engineer**~~assigned individual~~ determines that the work cannot be done in house, he**/she** obtains approval of the Engineering Supervisor to have the work performed by an external vendor.
3. When the work has been completed by the **Engineer**~~assigned individual~~ or the external vendor, the assigned individual documents the repairs made and the date the work was completed on the work order for entry in the CMMS.
4. If the repair work is done at or near the time of the equipment's scheduled preventive maintenance, the preventive maintenance schedule is updated accordingly.
5. If the repairs cannot be completed within 24 hours, the ~~assigned individual~~**Engineer** notifies the user department.
6. If the repair work is performed by an external vendor, the **E**engineer inspects or tests the equipment upon its return to make certain the repairs have been made properly and that the equipment meets appropriate electrical safety standards before returning it to the user department.
7. If the **E**engineer or external vendor determines that the equipment cannot be repaired, the

E~~e~~ngineer or **S**~~s~~upervisor returns the equipment to the user department with instructions to dispose of it in accordance with TCMC Policy **#8610-200** ~~and Procedure~~ "Equipment ~~Transfer/Disposal."~~**Transfer, Storage, Trade-in, and Disposal".**

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Maintenance And Inspection Medical Gas System~~ ~~Policy Number: 2003~~ ~~Page 1 of 1~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/01/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 6/09, 8/11, 5/12~~

SUBJECT: Maintenance and Inspection Medical Gas System

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 6/09, 8/11, 5/12

Department Approval Date(s):	**7/16**
Environmental Health and Safety Committee Approval Date(s):	**7/16**
Professional Affairs Committee Approval Date(s):	**01/17**
Board of Directors Approval Date(s):	

A. **PURPOSE**:
1. To describe the process by which the medical gas systems are maintained and inspected.

B. **GENERAL INFORMATION**:
1. Computerized Maintenance Management System (CMMS) - A computerized system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.

C. **POLICY:**
1. Normal and reserve supplies.
2. The Duty Engineer checks the normal and reserve supplies of liquid oxygen once each shift and documents the ~~levels~~ **levels on the daily round sheet**~~in the Engineering Services Log~~. Oxygen is ~~reordered when the tank gauge reads 75" 30"~~**-maintained between 75" and 25".**
~~2.~~**3. It is the responsibility of the Duty Engineer to reorder oxygen when the level is between 25" and 30"**.
~~3.~~**4.** The Duty Engineer checks the normal and reserve supply of nitrous oxide once each shift and documents the levels **on the daily round sheet**~~In the Engineering Services Log~~. Nitrous Oxide is re-ordered when the primary supply **is** exhausted and the secondary supply is activated. The Duty Engineer then shuts off the valve on the empty tanks to prevent backflow.
~~4.~~**5.** The Duty Engineer observes the delivery and transfer of oxygen. Invoices indicating volumes and purity delivered are kept on file in the Engineering Department.
~~5.~~**6.** Following periods of construction or evidence (e.g., alarms) that the system has been breached,

the medical gas system will be tested by ~~the Projects Department~~**a 3rd party** to verify that the gases being delivered are pure. Documentation of such testing will be kept on file in the Engineering Department.

~~6. In accordance with the CMMS environmental maintenance procedures for non-flammable anesthetizing locations, critical care areas and general patient care areas, an Engineer inspects the wall outlets and fittings for medical gas delivery and makes repairs as necessary. It is also verified that zone and control valves are labeled appropriately.~~

~~7. The Duty Engineer tests the low pressure alarm on the **master** control panel once each shift and documents such testing **on the daily round sheet**in the Engineering Services log.~~

~~8.~~**7.** A~~n outside~~ **qualified** vendor is contracted annually to perform an inspection of all master signals, area alarms, automatic pressure switches, shut off valves, flexible connections, outlets and purity from source in accordance with NFPA ~~and Joint Commission standards~~**to ensure compliance with Authorities Having Jurisdiction (AHJs)**.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: New Equipment: Inventory And Inspection~~ ~~Policy Number: 2007~~ ~~Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: New Equipment: Inventory and Inspection

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:	**7/16**
Environmental Health and Safety Committee Approval:	**7/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To outline the procedure by which new equipment is inventoried and inspected before release for patient care or other use.

B. **GENERAL INFORMATION:**
1. CMMS- A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
2. Environmental Unit- A space of manageable size in terms of square footage or work intensity classified by the principal activity which takes place within it.
3. Equipment Identification Number (EIN)- A number assigned to a specific piece of equipment, equipment grouping, or environmental unit for the purpose of identification and maintenance scheduling in CMMS.

C. **POLICY:**
1. ~~Except as indicated in Policy Statement 2 A~~**A**ll patient care equipment designated for use anywhere within the hospital shall be inspected and tested by the Engineering Department **or Biomedical Department** before initial use.
2. ~~Radiologic and nuclear imaging equipment will be inspected and tested before use by contracted Physicians.~~
3. ~~2.~~ New equipment which fails to pass the applicable electrical safety test will not be approved for use in the hospital until ~~such~~ **the** deficiencies have been corrected.

D. **PROCEDURE:**
1. The receiving department (Materials Management) notifies the Engineering Department that new equipment has been received.

2. ~~Following his inspection~~**Engineering performs new equipment inspection (places a safety sticker if successful)**~~,~~ **and** ~~the engineer~~determin**ationes** **is made** whether the equipment should be assigned an individual EIN, ~~and~~ maintenance schedul**e and instructionse** or should be considered part of its environmental unit and maintained as such.

~~2.~~**3. If the equipment fails to pass the required tests or does not meet the standards specified by the hospital, the equipment will be returned to the supplier by the Materials Management Department.** ~~(See Scheduled Equipment Maintenance Policy 2010.~~

~~3. When he assigns an individual EIN, the engineer also assigns to the equipment an instruction set and maintenance schedule (or prepares them if they do not already exist).~~

~~4. The engineer then performs a series of electrical tests on the equipment as outlined under Biomed Electrical Safety Test Procedure Manual, and if the equipment has been assigned an EIN, documents the inspection in the "comments" section of the Equipment File Form: "Incoming inspection performed (date)."~~

~~5. If the equipment fails to pass the required tests or does not meet the standards specified by the hospital, the engineer will note this in the "Comments" section of the Equipment File Form in the following manner: "To be held in the Materials Management Department pending U.L./City of Los Angeles approval (or correction of deficiency)."~~

~~6.~~**4.** ~~The engineer~~**Once above steps are completed, Engineering** ~~completes the rest of the Equipment File Form and~~ -enters **all** the **equipment** information **in**to the CMMS.

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Pre-Purchase Evaluations~~ ~~Policy Number: 2009 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Pre-Purchase Evaluations

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:	**07/16**
Environmental Health and Safety Committee Approval:	**07/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To outline the policy under which the Engineering Department will make pre-purchase equipment evaluations.

B. **POLICY:**
1. The Engineering Department will make pre-purchase evaluations of equipment at the verbal or written request of a user department, the medical center administration or a member of the professional staff.
2. Such pre-purchase evaluations shall be confined to:
   a. Construction quality
   b. Mechanical reliability
   c. Ease of maintenance
   d. Compatibility with existing systems and environment of anticipated use
   e. Underwriters Laboratories, or other agency approval
   f. Other information concerning the equipment about which Engineering Department personnel may be expected to be knowledgeable.
3. ~~Pre-purchase evaluations will not be made regarding the following types of equipment:~~
   ~~a. Imaging equipment~~
   ~~b. Clinical laboratory testing equipment~~
   ~~c. Word processors~~
   ~~d. Data processing equipment~~
   ~~e. Typewriters~~
   ~~f. Telecommunications equipment~~
4. ~~Evaluations will be given verbally unless a written evaluation is requested.~~

~~C. **DISTRIBUTION:**~~
~~All ar~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Purchasing Procedure~~ ~~Policy Number: 2011~~ ~~Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Purchasing Procedure

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:	**7/16**
Environmental Health and Safety Committee Approval:	**7/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the procedure for the purchasing of material or services by the Engineering Department.

B. **POLICY:**
1. Fill out **Purchase Requisition** ~~"Material / Services Information"~~ form as applicable.
2. Obtain approval from Director **of Engineering** or his/**her** designee.
3. Procure **a Purchase Order** (P.O.) **number#** from Materials Management. ~~and place on form~~.
4. Place the order with the vendor ~~being sure to get prices~~ and **obtain** delivery dates whenever possible. Be sure to place this information on the form.
5. **P.O. will be marked as received/completed in one of the following fashions:**
   - **a. When the goods are received at the receiving dock, the Purchasing Department will close the P.O. as received.**
   - ~~4.~~**b. For all other services, Engineering Department will approve invoice received against the appropriate PO and email a copy of the approved (by Director of Engineering or his/her designee) invoice to the Purchasing Department to mark the P.O. as received/completed.**

~~5. Secretary to enter P.O. in the computer system (Materials Management). A copy of signed P.O. and Material Service Information Form is sent to Accounting.~~
~~6. Goods or service received. Stamp receiver "Received Complete" and give to secretary to close out P.O. in computer.~~
~~7. If received incomplete, so note on receiver and process as above except do not stamp "Received Complete". When order or service send additional receiver to Accounting stamped "Received Complete".~~

~~C. **Distribution of Material / Services Information:**~~

~~1. 1st Copy---P.O.~~

~~2. 2nd Copy---File~~

~~3. 3rd Copy---Feedbac~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Scheduled Equipment Maintenance~~ ~~Policy Number: 2006~~ ~~Page 1 of 2~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Scheduled Equipment Maintenance

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:	**7/16**
Environmental Health and Safety Committee Approval:	**7/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the procedure for inspection, maintenance and repair **of Engineering equipment.** ~~of equipment deemed essential for life support or which is inherently more hazardous or complex~~.

B. **GENERAL INFORMATION:**
1. Scheduled Maintenance - Includes, as appropriate, inspection; preventative and corrective maintenance; functional testing, performance testing, calibration and safety testing.
2. Equipment - ~~As used in this procedure, equipment shall mean those individual inventoried items of equipment~~**life support, life safety, infection control and non-life support equipment** ~~which meets one or more of the following criteria:~~**maintained by the Engineering Department.**
~~a. Essential, directly or indirectly, for life support.Associated with a higher than normal incident risk during routine operation.~~
~~b. Requires, by reason of its complexity, a more intensive maintenance schedule.~~
~~c. Supplied, or maintained, by an external vendor.~~
3. Computerized Maintenance Management System (CMMS) A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
4. ~~Inventory Data Table~~**Equipment Inventory**: A table listing of all types of individually inventoried equipment and distinct environmental units or equipment groups, and including for each, the appropriate maintenance instruction**s, location** ~~number~~and frequency of maintenance. ~~This table includes non-patient care equipment that may pose an electrical hazard during intended use.~~
5. ~~Equipment File Listing by Location: A computerized list of all patient care and non-patient care equipment, powered and non-powered, in the facility, arranged by location of its use.~~

C. **POLICY:**~~Applied History by cost Center: A computerized record of all schedule and corrective~~

~~maintenance performed on all patient care and non-patient care equipment in the facility, arranged according to the cost center of us~~

1. Preventive Maintenance **(P.M.)** Work Orders will be ~~printed and issued~~ **assigned** on a monthly basis.
2. Assigned individuals, upon completing inspection and preventive maintenance, will note significant findings. The individual will then generate a corrective maintenance work order stating problem found. The corrective maintenance work order number will be logged on the Preventive Maintenance Work Order for equipment history purposes and noted in the comments section when closing out the Preventive Maintenance Work Order.
3. Scheduled P.M. work orders should be completed ~~within 30 days of scheduled start date with the exception of beds which have 90 days~~**by the assigned due date**. If the scheduled maintenance cannot be performed for any reason, ~~(i.e., equipment unavailable, departmental scheduling service contract schedule),~~ **the assigned individual must notify his/her immediate supervisor and document** such reason ~~is documented~~on P.M. work order.~~After reasonable attempts to perform procedure have failed, a statement will be sent to respective departments informing the Department Head that equipment was unavailable for inspection. The Department Head will be asked to make said equipment available for inspection.~~
4. ~~Upon second consecutive incidence of failure to inspect due to equipment not being found, the equipment will be dropped from inspection inventory. A statement regarding this drop will be sent to appropriate department.~~If scheduled maintenance is performed by an external vendor, the vendor will be instructed to perform maintenance in accordance with the work order and contract agreement. Any associated maintenance shall be documented. ~~Equipment and documentation shall be returned to Engineering Department within 30 days.~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: Utility Management Plan

ISSUE DATE: 9/94 **POLICY NUMBER: 4003**
REVIEW DATE(S): 8/15
REVISION DATE(S): 2/97, 5/00, 5/03, 6/06, 5/09, 6/12, 6/15, 10/15

Department Approval:	**08/15, 10/16**
Environmental Health and Safety Committee Approval:	**09/15, 10/16**
Professional Affairs Committee Approval:	**~~10/15~~01/17**
Board of Directors Approval:	**10/15**

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care and the range of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria including risks identified by outside sources such as, The Joint Commission (TJC) is used to eliminate or reduce the probability of adverse patient outcomes.
2. The Utility Systems Management Plan describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the TCHD and all outlying facilities operated and or owned by TCHD. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all staff, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
2. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective care and treatment are rendered to persons receiving services.
3. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

C. **OBJECTIVES:**

1. Design, operate and maintain utility systems serving the buildings that house the healthcare services of TCHD to provide a safe, comfortable, appropriate environment that supports patient care and business operations.
2. Perform recommended maintenance to maximize system service life and reliability.
3. Manage the Utility Systems Management program to assure compliance with The Joint Commission requirements.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering assures that an appropriate utility system maintenance program is implemented. The Director of Engineering also collaborates with the Director of Safety/EOC to develop reports of Utility Systems Management performance for presentation to the Environmental Health and Safety Committee (EHSC) on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other utility systems issues.
2. The Hospital's Board of Directors receives regular reports of the activities of the Utility Systems Management program from the EHSC. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Utility Systems Management program.
3. The Hospital's Chief Operating Officer (COO) or designee receives regular reports of the activities of the Utility Systems Management program. The COO or designee collaborates with the Director of Engineering and other appropriate staff to address utility system issues and concerns. The COO or designee also collaborates with the Director of Engineering to develop a budget and operational objectives for the program.
4. The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
5. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. **PROCESSES OF THE UTILITY SYSTEMS PLAN:**

1. **UM.EC.01.01.01 EP8 – Plan for the Safe, Reliable, Effective Operation of Utility Systems**
   a. The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of TCHD that may experience an adverse event while being monitored, diagnosed, or treated with any type of medical equipment or being housed in an environment supported by the utility systems of TCHD.
2. **UM.EC.02.05.01 EP1 – Design and Installation of Utility Systems**
   a. The Director of Engineering works with qualified design professionals, project managers and the intended end users of the space of TCHD to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of TCHD. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.
3. **UM.EC.02.05.01 EP2 – Determining System Risks and Developing and Inventory of Utility Systems and Equipment**
   a. All utility systems components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.
4. **UM.EC.02.05.01 EP3 – Maintenance Strategies**
   a. The Director of Engineering evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The

Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.

5. **UM.EC.02.05.01 EP4 – Inspection, Testing, and Maintenance Intervals**
   a. The Director of Engineering uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
   b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
   c. The Director of Engineering is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.
6. **UM.EC.02.05.01 EP5 – Management of Water Systems**
   a. The Director of Engineering and the Infection Preventionist are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
   b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
   c. The Director of Engineering and the Infection Preventionist are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
   d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.
7. **UM.EC.02.05.01 EP6 – Management of Ventilation Systems**
   a. The Director of Engineering and the Infection Preventionist are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
   b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Maintenance.
   c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.
   d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Engineering and Infection Preventionist develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.
8. **UM.EC.02.05.01 EP7 – Mapping of Utility Systems**
   a. The Director of Engineering is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.
9. **UM.EC.02.05.01 EP8 – Labeling of Controls for System Shutdown and Recovery**

a. The Director of Engineering is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.

10. **UM.EC.02.05.01 EP9 – 13 – Emergency Procedures**
a. The Director of Engineering and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
b. The Director of Engineering and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.

11. **UM.EC.02.05.03 EP1 – 6 and EC.02.05.07 EP1 - 10 – Inspection, Testing, and Maintenance of Emergency Power Systems**
a. The Director of Engineering is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
d. The Director of Engineering is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.
e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.
f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.
g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature

recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.

h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Administrative Director of Facilities, Engineering staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. **UM.EC.02.05.05 EP1 - Utility Systems Inventory and Initial Testing**
    a. The Director of Engineering establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.
    b. The Director of Engineering is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.
13. **UM.EC.02.05.05 EP3 - Testing of Life Support Equipment**
    a. The Director of Engineering assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
14. **UM.EC.02.05.05 EP4 - Testing of Infection Control Support Equipment**
    a. The Director of Engineering assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
15. **UM.EC.02.05.05 EP5 - Testing of Non-Life Support Equipment**
    a. The Director of Engineering assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
16. **UM.EC.02.05.09 EP1 - Medical Gas System Testing**
    a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.
17. **UM.EC.02.05.09 EP2 - Modifying / Repairing Medical Gas Systems**
    a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering maintains a permanent record of all certification testing.
18. **UM.EC.02.05.09 EP3 - Labeling & Accessibility of Medical Gas Controls**
    a. The Director of Engineering is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
    b. In addition, the Director of Engineering is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled environmental tours. Deficiencies are reported to the appropriate manager for resolution.
19. **EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment**
    a. The Sr. Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety/EOC works with the Sr.

Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.

b. The completed reports are forwarded to the Sr. Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

c. In addition, the Sr. Director of Risk Management and the Director of Safety/EOC collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the EHSC and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Director of Safety/EOC provides summary information related to incidents to the CEO or designee and other leaders, including the Board of Directors, as appropriate.

d. The Director of Safety/EOC coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six EC functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

e. The EHSC and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

f. The Director of Safety/EOC and the Environmental Health and Safety Committee and the Patient safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

20. **EC.04.01.01 EP15 – Every twelve months the hospital evaluates each Environment of Care Management Plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.**

a. The Director of Safety/EOC coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, benchmarking programs, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Director of Safety/EOC.

d. The results of the annual evaluation are presented to the EHSC. The Committee reviews

and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, the Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

21. **EC.04.01.03 EP1 – 3 - Analysis and actions regarding identified environmental issues**
    a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
22. **EC.04.01.05 EP1 – 3 – Improving the Environment**
    a. When the leadership of the hospital, performance improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.
23. **LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3 – Orientation and Ongoing Education and Training**
    a. Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.
    b. In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes the procedures and controls, laws and regulations, and the state of the art of environmental safety.
    c. The Human Resources Department with assistance from the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work.
    e. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
    f. The Director of Safety/EOC collaborates with the Environment of Care managers, department heads, the Director of Performance Improvement, the Director of Infection Control, and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.
    g. The Director of Safety/EOC gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.
    h. In addition the Director of Safety/EOC evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when

an environmental incident occurs and how to report environment of care risks or incidents.

i. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **AFFECTED PERSONNEL / AREAS:**

1. GOVERNING BOARD; MEDICAL STAFF; ALL HOSPITAL EMPLOYEES; VOLUNTEERS; VENDORS; CONTRACT SERVICES AND STAFF;

G. **REFERENCES:**

1. The Joint Commission

Tri-City Medical Center
Oceanside, California

ENGINEERING
OPERATIONS

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Work Order Requests~~ ~~Policy Number: 2010 Page 1 of 1~~
~~Department: Hospital-Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 9/94; 1/97; 5/00; 5/03, 6/06; 5/09, 8/11, 6/12~~

SUBJECT: Work Order Requests

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 9/94, 1/97, 5/00, 5/03, 6/06, 5/09, 8/11, 6/12

Department Approval:	**7/16**
Environmental Health and Safety Committee Approval:	**7/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To describe the process by which requests for Engineering will be processed and documented.

B. **GENERAL INFORMATION:**
1. Work Order Requests- Work orders generated by a user department and transmitted via the Computerized Maintenance Management System.
2. Computerized Maintenance Management System (CMMS) - A computerized information system used to facilitate the scheduling, monitoring and documentation of equipment and environmental maintenance.
3. Emergency Services - Those Engineering services needed to resolve problems or conditions which pose an immediate threat to patient or employee safety or which may significantly affect the ability of a department or area to carry out an essential function. ~~Emergency service is normally obtained via a telephone call to the Facilities Management Office (see "Hours of Service").~~

C. **POLICY:**
1. The priority with which work orders ~~(~~received either by telephone or C**MM**~~CN~~S will be handled will be determined by the Engineering Supervisor or designee.
2. Emergency work ~~orders,~~**orders** ~~as defined above,~~ will be assigned to an **E**engineer for immediate handling.

D. **PROCEDURE:**
1. The Engineering Supervisor or designee checks the ~~computer terminal in the Engineering Shop~~**CMMS** at least twice each hour for work orders which have been generated by user

departments.

2. The Engineering Supervisor or designee reviews the work orders received, determines the priority with which they must be handled, and assigns them to an **E**engineer.
3. The **E**engineer to whom the request is assigned completes the work or notifies the Engineering Supervisor or designee of any reason why it cannot be completed promptly, (i.e., lack of parts, lack of familiarity with equipment, etc.).
4. When the work has been completed, the assigned **E**engineer documents the total man hours and materials used, and **closes the work order in CMMS**~~signs the work order~~.
5. ~~The assigned engineer closes out the work order.~~

SUBJECT: Fire Safety Hazards

ISSUE DATE: 10/15
REVIEW DATE(S):
REVISION DATE(S):

Department Approval:	**08/15, 6/16**
Environmental Health and Safety Committee Approval:	**09/15, 6/16**
Professional Affairs Committee Approval:	**~~10/15~~01/17**
Board of Directors Approval:	**10/15**

A. **POLICY:**

1. Hazards that personnel shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:
   a. Careless Smoking - Be careful to observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes & vapor devices).
   b. Exit Ways - Do not permit the obstruction of aisles, doorways, fire escapes or allow their use as storage places.
   c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.
   d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.
   e. Flammable Liquids - (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.
   f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.
   g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.
   h. Electric Heaters - These units, particularly the portable type, are not permitted anywhere on the hospital premises unless approved by Engineering. No portable heaters are

allowed in patient care areas.

i. Heat generating devices or substances such as candles, ~~toasters, toaster ovens,~~ hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. **Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker.** Persons who do not comply with these directions will be subject to the disciplinary process.

B. **AFFECTED AREAS/PERSONNEL:**

1. Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors

C. **REFERENCE(S):**

1. The Joint Commission
2. NFPA
3. CA State Fire Marshall

Tri-City Medical Center
Oceanside, California
Environment of Care
Hazardous Material Management

SUBJECT: Hazardous Material and Waste Management and Communication Plan

ISSUE DATE: 11/87 **POLICY NUMBER: 6000**
REVIEW DATE(S):
REVISION DATE(S): 09/94, 07/97, 09/00, 04/03, 12/10, 05/15

Department Approval:	**04/15, 06/16**
Environmental Health and Safety Committee Approval:	**04/15, 09/16**
Professional Affairs Committee Approval:	**~~05/15~~01/17**
Board of Directors Approval:	**05/16**

A. **DEFINITIONS OF HAZARDOUS MATERIALS:**

1. Those materials that by their nature are a potential threat to the health and safety of persons coming into contact with them.
   a. Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5 and liquids that corrode steel at a rate of greater than .25 inch per year.
   b. Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.
   c. Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point of less than 140F, and solids that ignite spontaneously through absorption of moisture or friction.
   d. Reactive (Explosives) - substances that are unstable and readily undergo violent change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
   e. Pharmaceutical waste and Expired Medications - Expired or unusable parenteral/oral liquids; dextrose/saline I.V. admixtures/solutions containing: antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline, TPN; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol. Expired Unusable Pharmaceuticals: Intact expired or unusable medications.

B. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

C. **POLICY**

1. Tri-City ~~Medical Center~~**Healthcare District** is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in compliance with State and Federal regulations.
2. Right to Know Law
   a. Employees and contractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious Materials. While performing duties at Tri-City ~~Medical Center~~**Healthcare District facilities**, employees and contractors shall be informed so they can make a

more knowledgeable and reasoned decision with respect to any associated personal health hazards.

b. General Orientation: New employees will be informed of "Right to Know Law" during the Safety portion of Employee Orientation.
   i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with ~~Material~~ Safety Data Sheet information.
   ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.

c. Instructional signs informing employees of their rights under the law are posted. Department Specific Orientation: At the time of initial assignment, all employees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, he or she need not be trained.

d. Contracting for Outside Services:
   i. Departments that obtain outside services through contracts or service agreements will insure that the contractor has been informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the ~~Non-~~**Non-**Tri-~~City Medical Center~~**Healthcare District** Employee Orientation Program.

D. **GUIDELINES**:

1. Method of Identification of Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by Manufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors of Engineering, Surgery, Nutrition, **Laboratory, Pharmacy, and** EVS, will submit a list of substances determined to be hazardous by this policy **to the Safety Officer**. This list will be updated as new products determined to be hazardous are introduced to the department.
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. Safety Data Sheets (SDS)-3 E Company Fax on Demand:
   a. Request an SDS when assistance is needed with medical emergencies, chemical spills, and employee
      i. **Emergency Request** – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.
      ii. **Immediate to 30 minutes:** Regulatory Agency Request (OSHA, EPA, The Joint Commission).
      iii. **Immediate to 3 hours:** Employee request (non-emergency)
      iv. **Standard Request** – Immediate to 24 hours: Customer Request, Contractor Request.
      v. **Mail Request** – Rush: mailed within 24 hours – Standard: mailed within 3 business days: Request of 10 or more Safety Data Sheets.
   b. To initiate SDS request follow the following procedure:
      i. Call Toll Free: 1-800-451-8346 or 760-602-8703, to request up to nine SDS.
      ii. Fax request to (760-602-8888 for orders and numbers on SDS of SDS sheets
      iii. **DO NOT FAX EMERGENCY SDS REQUESTS – CALL IMMEDIATELY**
   c. To request a SDS complete the attached request form then call, fax or mail to 3 E Company. Provide as much of the following information as possible:
      i. Product name.

ii. Manufacturer name.
iii. Product number.
iv. UPC Code (if available).
v. Be specific when request is for a product. Separate SDS are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready – to use).

3. Employee Training:
   a. Department directors are responsible for providing training to employees on hazardous materials in their work area at the time of their initial assignment/ or reassignment and when a new hazard is introduced into their work area. All employees must complete the Annual Computer Based Learning (CBL's) modules which include a section on Hazardous Materials/Global Harmonization/Right-to-know training. The CBL instructions include the following items:
      i. Employee rights under the law.
      ii. Explanation of the (SDS)
      iii. Explanation of the labeling system and pictograms
      iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.
      v. Safety and control devices to include personal protection.
      vi. Location of hazardous substance list.
      vii. Emergency procedures for spill control.
      viii. Review of blood-borne diseases and potential for transmission.
      ix. Types of protective equipment and proper use.
      x. Situations requiring use of protective equipment.
      xi. Review of concept of standard precautions as it applies to the employees specific work practices.
      xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.
      xiii. Training in proper handling of needles and sharps along with proper disposal
      xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.
      xv. Department Directors will ensure that all employees annually complete the Computer Based Learning module on Hazardous Materials. .

4. Hazardous Chemical Waste & Infectious Medical Waste Disposal
   a. General Disposal Guidelines:
      i. Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
      ii. Wear appropriate protective equipment (i.e. gloves, safety glasses, lab coat and respirator where applicable).
      iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will placed into the Chemical Waste Storage Shed for final disposal.
      iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
      v. Tri-City Healthcare District is contracted with an outside company for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.
      vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
      vii. Waste Pharmaceuticals – Refer to AP&P # 276 Handling of

Pharmaceutical Waste, Expired Medications & Expired IV Solutions.

b. Monitoring:
   i. Waste Gas Levels (Surgical Suites):
   ii. Waste gas levels in surgical areas are to be tested at least ~~quarterly~~**annually**.
   iii. Testing is to be conducted by an independent testing company contracted by Tri-City Healthcare District.
   iv. Results of such testing are to be kept on file by the respective departments.
   v. Results of the ~~quarterly~~ **annual** testing should be posted along with the maximum permitted levels of the gases tested for employee review.
   vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.

c. Airflow Testing:
   i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
   ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
   iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to insure that gas levels remain at safe levels and do not affect air quality, fumehoods should remain running at all times.

d. Radiation
   i. All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.

e. Formaldehyde Testing
   i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
   ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
   iii. Employees working with solutions of 1% or more formaldehyde will utilize protective equipment as follows:
      1) Safety Glasses.
      2) Gloves.
      3) Disposable chemical resistant Lab coats.

f. Work Test Area:
   i. Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the Environment of Care/Safety Officer.
   ii. Levels exceeding permitted safe limits will be reported to the Safety Officer.
   iii. A consultation with Administration, EOC/Safety Officer and the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to insure employee safety.

g. Employee Monitoring and Medical Testing:
   ~~i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gasses. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.~~
   ~~ii.~~**i.** Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can be conducted.

~~iii.~~**ii.** Testing will be done under the supervision of a licensed qualified physician.

h. Storage and Transportation:
   i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire. Further, flammable liquids will be stored away from flammable gases. Thus, in the event of fire the possibility of explosion is reduced and containment is readily achieved.
   ii. All openings will be controlled with approved self-closing fire doors.
   iii. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour. The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.
   iv. Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.
   v. Cylinders will be stored separately (rooms) from flammable material
   vi. Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.
   vii. Incompatible materials will be stored away from each other.
   viii. Materials will be transported in approved safety containers or in their original shipping packages.
   ix. No hazardous material will be transported to and stored in areas other than work or storage areas.
   x. Materials will be transported in amounts comparable to regulated daily or weekly limits.
   xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.
   xii. All materials packaged and shipped for outside disposal must comply with Department of Transportation (DOT) regulations.
   xiii. Daily limits will be stored in approved safety cabinets.

i. Emergency Response Procedures:
   i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur. The following procedure is outlined in the event that such a chemical spill occurs within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.
      1) Areas of concern:
         a) Laboratory - Large variety of chemicals.
         b) Pharmacy - Large variety of chemicals.
         c) Materials Management - Cleaning supplies and hospital chemical supplies.
         d) Environmental Services - Cleaning supplies and solvents.
         e) Radiology ~~–Materials used in x-ray development and radioactive~~ **Radioactive** material.
         f) Food and Nutrition - Degreasers and cleaning supplies.
         g) Respiratory –Disinfectants-.
         h) Facilities Management - Large variety of chemicals.
         i) Sterile Processing Department – Disinfectants.
         j) Surgical Services – Tissue Fixative.

j. Chemical Spills:
   i. Immediately alert personnel in area.
   ii. Dial "66" and tell PBX Operator that there is a chemical spill and the location.
   ~~i.~~**iii. The PBX Operator will alert: The Environment of Care/Safety Officer, Manager of Environmental Services or Lead EVS, Manager of Security or Lead Officer, and Engineering.**

iv. Evacuate and seal off areas from a safe distance; if flammable are involved, eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the Environment of Care/Safety Officer has been notified and arrives on scene.

~~ii.~~**v.** **Contact 3 E Company 1-800-451-8346 for Safety Data Sheet (SDS) information on how to handle the spill and what type of Personal Protective Equipment is needed. 3 E Company will fax the information within minutes to the closest fax machine number provided. Employees will need to know the name of the chemical to tell the 3 E Company operator.**

~~iii.~~**vi.** If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The Environment of Care/Safety Officer will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.

~~iv.~~**vii.** Notification of the fire department will depend on the type of the spill and the potential danger involved.

~~v.~~**viii.** If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no immediate danger to employee(s) then:

1) **Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.**
2) Contact Environmental Services **(EVS)** who will contain **the** spill**, and clean the chemical up** per ~~department~~**SDS guidelines.**
3) **All collected chemicals must be handles per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.**
~~1)~~**4) Contact the Environment of Care/Safety Officer with any questions.** ~~specific policy and who will contact the Environment of Care/Safety Officer.~~

k. Treatment ~~Of~~ **of** Contaminated Area:
   i. Wash area immediately.
   ii. Clothing contamination: Take item of clothing off immediately to prevent soaking through and contaminating skin. This includes all clothing affected.
   iii. First Aid~~r~~:
      1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.
      2) Do not try to neutralize.
         a) Go to the Emergency Department immediately after flushing affected area.

E. GOALS/OBJECTIVE FOR FY17

1. **Provide face-to-face training to all applicable Pharmacy and Engineering employees on how to properly respond to a chemical spill. Measurement will be number of applicable employees/number of employees receiving the spill management training. Goal is 100% of applicable employees.**
2. **Complete the conversion over to Stericycle as the hazardous waste management provider and complete an assessment of new options related to disposable of controlled substances.**

~~E.~~F. REFERENCES

1. AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: Life Safety Management Plan

ISSUE DATE: 11/87
REVIEW DATE(S): 03/00, 04/106, 04/09
REVISION DATE(S): 04/13, 05/12

Department Approval:	**05/15, 06/16**
Environmental Health and Safety Committee Approval:	**06/15, 08/16**
Professional Affairs Committee Approval:	**~~06/15~~01/17**
Board of Directors Approval:	**06/15**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District. The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Tri-City Healthcare District.
2. The Management Plan for Life Safety describes the risk and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities. The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care facilities of Tri-City Healthcare District. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District.

B. **PRINCIPLES:**

1. All buildings of Tri-City Healthcare District housing patient care services must be designed, operated, and maintained to comply with the ~~2000~~ **2012** edition of the National Fire Protection Association (NFPA) Life Safety Code**, and the 2012 Edition of the NFPA Health Care Facilities Code**.
2. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
3. All staff must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
4. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

1. Design and construct all spaces intended for housing patient care and treatment services to

meet national, state, and local building and fire codes.

2. Conduct required fire drills in all buildings of Tri-City Healthcare District housing patient care services.
3. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
4. Inspect and maintain all buildings housing patient care services to assure compliance with the applicable requirements of the ~~2000~~ **2012** edition of the NFPA Life Safety Code **and the 2012 Edition of NFPA Health Care Facilities Code**.
5. Train all staff, volunteers, and members of the medical staff to respond effectively to fires.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering (Facilities Manager) assures that an appropriate maintenance program is implemented. The Director of Engineering (Facilities Manager) also collaborates with the Safety Officer to develop reports of Life Safety Management performance for presentation to the Environmental Health & Safety Committee on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
3. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.
4. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program from the Environmental Health & Safety Committee. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering (Facilities Manager) and appropriate clinical staff. The Board collaborates with the CEO and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
5. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Engineering (Facilities Manager) and other appropriate staff to address fire safety issues and concerns.

E. **ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:**

1. Life Safety Management Plan (FS.EC.01.01.01 EP6)
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Tri-City Healthcare District experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property (FS.EC.02.02.01 EP1)
   a. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Engineer (Facilities Manager) and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to assure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments.

The Director of Engineer (Facilities Manager) assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer (Facilities Manager) permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of Tri-City Healthcare District.

c. Management
   i. The **Director of Engineer** (Facilities Manager) oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.
   ii. The Director of Engineer (Facilities Manager) is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process
   i. The Safety Officer is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of Tri-City Healthcare District. The current fire response plan is based on the remove from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.
   ii. The emergency number "66" is to be dialed to report a fire.
   iii. The unattached buildings located on the Medical Center campus will dial "66" to report a fire.
   iv. All buildings off the main Medical Center campus will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds (FS.EC.02.03.01 EP2 & EC.02.01.03 EP1)
   a. Tri-City Healthcare District has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.
   b. Tri-City Healthcare District has identified alternatives to tobacco products that are offered to all. Tri-City Healthcare District has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.
   c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.
4. The hospital maintains free and unobstructed access to all exits (FS.EC.02.03.01 EP4)
   a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Officer, and the Environmental Health & Safety Committee.
5. The hospital has a written fire response plan (FS.EC.02.03.01 EP9-10)
   a. The Safety Officer is responsible for coordinating the implementation of the fire response plan. All staff is oriented to the RACE response model and effective use of portable fire extinguishers. In addition, all staff are oriented to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.
   b. The department and area specific fire response plans include information about:
      i. The roles of all employees, medical staff, volunteers, contract staff and students

near the point of fire origin.

ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

1) Note: Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.

iii. Operation of the fire alarm system.

iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

6. Fire Drills (FS.EC.02.03.03 EP1 – 5)
   a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
   b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
   c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
7. Inspection, Testing, and Maintenance of Fire Safety Systems (FS.EC.02.03.05 EP1 – 20)
   a. The Director of Engineering (Facilities Manager) works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the National Fire Protection Association or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes. The hospital conducts monthly evaluations of nuclear powered exit signs and verified for expiration dates and replaced accordingly.
   b. When deficiencies are identified, they are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Officer.
8. Life Safety Management (LS.EC.01.01.01 EP1 – 3)
   a. The Director of Engineering (Facilities Manager) is responsible for maintaining the Statement of Conditions. The Director of Engineering (Facilities Manager) prepares a quarterly report of the rate of completion of any Plan for Improvement for the Environmental Safety Committee. If any items will not be completed within the established timeframe plus The Joint Commission allowed six month grace period, the Director of Engineering (Facilities Manager) is responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.
9. Management of Fire Safety Risks (LS.01.02.01 EP1 – 14)

a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – ~~2000~~ **2012** Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
b. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
c. The Director of Engineering (Facilities Manager) and Safety Officer are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Director of Engineering (Facilities Manager) take appropriate action to resolve the deficiencies.
d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Environmental Health & Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EC.04.01.01 EP11)
a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
b. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
d. The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of Tri-City Healthcare District.
e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
f. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
g. The Safety Officer prepares a quarterly report to the leadership of Tri-City Healthcare District. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

h. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. **Semi-annual reports are provided to the Board of Directors related to the EC activities.**

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.
    c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Officer.
    d. The Environmental Health & Safety Committee reviews and approves the annual reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, The Board of Directors, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.
12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – 3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
13. Improving the Environment (EC.04.01.05 EP1 – 3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with Environmental Health & Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1

and EC.03.01.01 EP1 – 3)

a. Orientation and training addressing subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.
b. In addition, all current employees complete an annual review of life safety via a CBL module and documented in the Netlearning system.
c. The Human Resources Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
e. The Safety Officer collaborates with the Environment of Care managers, department heads, the Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job related risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff members understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. GOALS /OBJECTIVES FOR FY17

1. **Complete an assessment of TCHD compliance to the new 2012 Life Safety Codes and Health Care Facilities Codes and have action plans for any areas found to not meet the new standards.**
2. **Complete a thorough hospital-wide review of all fire alarm and suppression systems by Red Hawk.**
3. **Work with staff to create a better working knowledge and adaption of NFPA 2012 standards to existing policies and procedures.**
4. **Continue to work with staff and contractors in regards to both pre and post activities during construction phases that are necessary to maintain the safety of staff, patients and visitors to the facility.**

~~F.~~ G. REFERENCES:

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)
2. **The 2012 Edition NFPA 101 Life Safety Code**
~~1.~~ 3. **The 2012 Edition NFPA 99 Health Care Facilities Code**

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Security Management

SUBJECT: **Security Management Plan**

ISSUE DATE: 01/97
REVIEW DATE(S): 01/99
REVISION DATE(S): 07/00, 04/03, 12/05, 12/11

Department Approval:	**05/15, 06/16**
Environmental Health and Safety Committee Approval:	**06/15, 09/16**
Professional Affairs Committee Approval:	**~~06/15~~01/17**
Board of Directors Approval:	**06/15**

A. **EXECUTIVE SUMMARY**

1. Each environment of care poses unique security risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The security management program is designed to identify and manage the security risks of the environments of care operated and owned by Tri-City Healthcare District. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. A security management program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified.
2. The Management Plan for a Secure Environment describes the security risk and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the security of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The scope of the program is applied to the medical center and all offsite care centers owned and operated by Tri-City Healthcare District. The Security Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District. The plan also affects all employees, volunteers, medical staff and associates including contracted services of Tri-City Healthcare District.

B. **PRINCIPLES**

1. Security is a system made up of human assets and technology.
2. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, staff, and others coming to Tri-City Healthcare District.
3. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing Tri-City Healthcare District.
4. Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.
5. Staff awareness of security is an essential part of an effective program. Tri-City Healthcare District orients and trains all staff to basic components of the security program and to techniques for managing security risks related to work areas or daily activities.

C. **OBJECTIVES**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities,

and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Tri-City Healthcare District.

2. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.
3. Analyze security incidents and occurrences to identify root cause elements.
4. Conduct ongoing random security patrols in all areas of the medical center, affiliated business offices and outpatient facilities. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas and all patient care areas at least once per day.
5. Present reports of Environment of Care management activities to the Environmental Health & Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The Security Manager coordinates the documentation and presentation of this information.
6. Assure that departments have current organization-wide and as needed department specific procedures and controls designed to manage identified security risks.
7. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.
8. Assign qualified individuals to manage the program and to respond to immediate security threats.
9. Perform an annual evaluation of the management plan and of the scope, objectives performance and effectiveness of the security program.
10. Design and present security education and training to all new and current employees, volunteers, members of the medical staff, contract staff and others as appropriate.
11. Provide timely response to emergencies and requests for assistance.
12. Communicate with law enforcement and other civil authorities as needed.
13. Manage access to the grounds, buildings, and sensitive areas of Tri-City Healthcare District.\

D. **PROGRAM MANAGEMENT STRUCTURE**

1. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the Security program from the Environmental Health & Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer.
2. The Board collaborates with the CEO and other senior leaders to assure budget and staffing resources are available to support the Security Program.
3. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Security program. The CEO or designee collaborates with the Security Manager and other appropriate staff to address security issues and concerns.
4. The Security Manager works under the general direction of the CEO or designee. The Security Manager, in collaboration with the Safety Officer, is responsible for managing the Security Program. The Security Manager reports program findings to the Environmental Health & Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
5. Department leaders are responsible for orienting new staff members to the department and to job and task specific security procedures. The orientation and ongoing education and training emphasize patient safety. Department heads are also responsible for participating in the reporting and investigation of incidents occurring in their departments.
6. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

E. **ELEMENTS OF THE SECURITY PLAN**

1. Appointment of Security Leadership (SEC.EC.01.01.01 EP1)
   a. The CEO of Tri-City Healthcare District appoints the Safety Officer, and selects a

qualified individual capable of overseeing the development, implementation and monitoring of the security program. The Safety Officer's job is defined by a job description. The CEO or a designee evaluates the competence of the Safety Officer annually.

b. The Security Manager coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The Security Manager's job is defined by a job description. The CEO or a designee evaluates the competence of the Security Manager annually.

c. The Security Manager maintains a current knowledge of laws, regulations, and standards of security. The Security Manager also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of Tri-City Healthcare District.

2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)

a. The Emergency Management program includes specific response plans for Tri-City Healthcare District that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the HICS (Hospital Incident Command System) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.

b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Management Plan for a Secure Environment (SEC.EC.01.01.01 EP4)

a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of Tri-City Healthcare District experience an adverse security event.

4. Proactive Risk Assessment (SEC. EC.02.01.01 EP1)

a. The Security Manager of Tri-City Healthcare District coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.

b. The Security Manager works with department directors, managers, the Patient Safety Officer, Risk Management and others as appropriate.

c. The Security Department will be responsible for enacting proactive security measures as follows:

i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/accidents.

ii. Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspections of all sensitive areas throughout the Medical Center.

iii. Ensuing that all employees and physicians properly display their photographic identification badges at all times.

iv. Submitting reports to the Director of Engineering pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and Women's Center. Security will also ensure a location for long-term vehicle parking.
vi. Monitoring the Security Department CCTV.
vii. Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. Tri-City Hospital District has elected to implement the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of staff in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.
      v. Characteristics of aggressive and violent patients and victims.
      vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
      vii. Strategies to avoid physical harm.
      viii. Restraining techniques.
      ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).
   c. A condensed version of the NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Security Manager follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Security Manager assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors. The directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job related policies, procedures and controls. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The Security Manager coordinates the reviews of procedures with department leaders and other appropriate staff.
7. Identification of Patients, Staff, and Others Entering the Facility (SEC.EC.02.01.01 EP7)
   a. The identification of staff is an interdisciplinary function. Several Directors share

responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.

b. The current systems in place at Tri-City Healthcare District include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.

c. The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.

d. The identification of others entering Tri-City Healthcare District is managed by the Security and Materials Management Departments. The Security Manager in collaboration with the CEO or designee and other appropriate staff provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The Security Manager takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to Tri-City Healthcare District.

8. Identification and Management of Security Sensitive Areas (SEC.EC.02.01.01 EP8)

a. The following areas have been designated as sensitive areas:

i. Emergency Department.
ii. Behavioral Health **and Crisis Stabilization** Units.
iii. Maternal Child Health.
iv. Neonatal Intensive Care Unit.
v. Pharmacy Department.
vi. Human Resources Department.
vii. Adult Critical Care Unit.
viii. Information Technology.
ix. Administration.
x. 3rd Floor Center Tower ~~California Department of Corrections~~**Progressive Care** Unit.
xi. Medical Records Office and Storage areas.
xii. Nuclear Medicine Hot Lab.

b. Staff in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.

c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:

i. Emergency Department:
1) Electronic access control.
2) Panic buttons.
3) Closed Circuit Television (CCTV) cameras.
4) Security Officer Station – Posted 24 hours per day.

ii. Behavioral Health Units:
1) Electronic access control.
2) CCTV.

iii. Maternal Child Health Units:
1) Electronic access control.
2) Access Control System CCTV.
3) Department policy in place for identifying visitors.
4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security

processes.
6) Unique identification for staff members.

iv. Neonatal Intensive Care Unit:
1) Electronic access control.
2) The Maternal Child Health units are protected with both active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs.

v. Pharmacy Department:
1) Electronic access control.
2) Infrared Security System.

vi. Business Office:
1) Electronic access control.
2) Panic button.
3) Local area surveillance system.

vii. Human Resources department:
1) Panic buttons.
2) Access Control System CCTV.

viii. Adult Critical Care Unit:
1) Electronic access control.

ix. Patient Representative Office:
1) Panic button.

9. Management of Security Incidents Including an Infant or Pediatric Abduction (SEC.EC.02.01.01 EP9)
   a. The Security Manager has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The Security Manager or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.
   b. The Security Manager, Safety Officer and the Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.
   c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
      i. All available staff responds per the Patient Care Services Code Adam.
      ii. The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.
   d. The Security Manager and the Director of Women and Newborn Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.
10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EP11)
   a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Security Manager works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
   b. Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

c. In addition, the Director of Risk Management and the Security Manager collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

d. The Security Manager works with the Environmental Health & Safety Committee to collect information about security deficiencies and opportunities for improvement from all areas of Tri-City Healthcare District. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

e. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

f. The Safety Officer and the Patient Safety Committee prepare a quarterly report to the leadership of Tri-City Healthcare District. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)

a. The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

c. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of the Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

d. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

e. The results of the annual evaluation are presented to the Environmental Health & Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The

manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment (EC.04.01.05 EP1 – EP3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the Environmental Health & Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual EOC training is provided and documented via NetLearning.
    c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program. New employees are required to attend the general NEO orientation program within 30 days of their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.
    e. The Safety Officer collaborates with the Environment of Care leaders, the Director of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.
    f. The Safety Officer gathers data during environmental EOC rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. The EOC Rounds evaluate the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    g. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is

taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. GOALS AND OBJECTIVES FOR FY2017

1. **Complete an assessment of the parking lot camera coverage with HCI and create and action plan for installation of cameras throughout the campus to improve visibility of the parking lot. Add signage throughout the parking lot alerting individuals that cameras are in use.**
2. **Creation of the Outpatient Psychiatric Crisis Stabilization Unit (CSU) in BHU. Measure of success will be the unit is opened and operational with CDPH approval.**
3. **Add the following safety precautions to the CSU for both patient and staff safety:**
   - a. **Fixed post officer**
   - b. **Cameras and monitors to improve observation of the patients**
   - c. **Add key pad door locks to strengthen access control to key locations**
   - ~~h.~~d. **Creation of a new close observation room on the Inpatient side (pending OSHPD approval)**

~~F.~~G. RELATED DOCUMENTS:

1. Patient Care Services Code Adam Policy

~~G.~~H. REFERENCES:

1. The Joint Commission **Standards**
2. **Cal/OSHA Workplace Violence Prevention requirements**

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Equipment Management

SUBJECT: **Medical Equipment Management Plan**

ISSUE DATE: 10/94
REVIEW DATE(S): 03/97, 7/00, 05/03, 05/08
REVISION DATE(S): 03/97, 7/00, 05/03, 05/08

Department Approval:	**05/15, 06/16**
Environmental Health and Safety Committee Approval:	**06/15, 08/16**
Professional Affairs Committee Approval:	**~~06/15~~01/17**
Board of Directors Approval:	**06/15**

A. **SCOPE:**

1. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at Tri-City Healthcare District.
2. The program is applied to Tri-City Healthcare District medical center and offsite care locations. \
3. The Medical Equipment Management Plan describes the processes it implements to manage the effective, safe, and reliable operation of medical equipment as well as provide a safe environment for patients, staff members, visitors, and other individuals in the hospital. Directly or indirectly, the Medical Equipment Management Plan involves every person in the hospital who uses, maintains, or is associated with medical equipment.

B. **FUNDAMENTALS (RISKS):**

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. **OBJECTIVES:**

1. The Objectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours. The Objectives for this Plan are:
   a. To increase training, both formal and informal for all resident technicians.
   b. Develop departmental rounds to ensure medical equipment safety within the facility.
   c. Keep the medical equipment inventory current and accurate.
   d. Minimize risks to patients, users, and the environment.
   e. Maintain the highest level of availability of medical equipment to clinical users.
   f. Reduce the need for premature replacement of equipment.
   g. Comply with applicable laws, regulations, standards, and codes.

h. Continually seek opportunities for quality improvement and cost reduction.
i. Reduce unnecessary workload that does not produce positive impact of care delivery.

D. **ORGANIZATION & RESPONSIBILITY:**

1. The Hospital Governing Board receives regular reports of the activities of the Medical Equipment Management Program from the Environmental Health and Safety Committee. They review the reports and, as appropriate, communicate concerns about identified issues, and regulatory compliance. They provide support to facilitate the ongoing activities of the Medical Equipment Program.
2. The Chief Operating Officer (COO) receives regular reports of the current status of the Medical Equipment program through the Environmental Health & Safety Committee. The COO reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, Clinical Engineering, and other appropriate staff.
3. The Manager of Clinical Engineering with COO support assures that the Medical Equipment Program is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty service contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
4. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
5. Department heads orient new staff to their department and, as appropriate, specific uses of medical equipment. When requested, the Clinical Engineering Technicians provides assistance.
6. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. **PERFORMANCE ACTIVITIES:**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure important aspect of the Medical Equipment Program.
2. The following fundamental performance indicators will be monitored:
   a. SM completion rate benchmark is 95% or greater.
   b. Repair completion rate within 30-days benchmark is 85% or greater.
   c. Critical/High Risk Equip SM Mthly Completion rate is 100%.
   d. Use Error Percentages
   e. Could not Duplicate Percentages per year
   f. Equipment found without PM Safety Sticker <1%
3. As they occur:
   a. Safe Medical Device Act of 1990 (SMDA)
   b. Incident investigations
   c. Device recalls and alerts

F. **PROCESSES FOR MANAGING MEDICAL EQUIPMENT:**

1. The hospital plans activities to minimize risks in the environment of care – EC.01.01.01 EP7
   a. The hospital has a written plan for managing medical equipment. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at Tri-City Healthcare District.
2. The hospital manages safety and security risks- EC.02.01.01 EP11
   a. The hospital responds to product notices and recalls. The Manager of Clinical Engineering responds and acts on medical equipment notices and recalls. Any notices or recalls (OEM voluntary or FDA) which are affected on any devices or equipment in the

facility will be acted on immediately and reported to the EHSC meeting. The Department Director (owner of the equipment) and Risk Manager will be notified of the notice or recall and action taken. The notice or recall will be annotated on the EHSC medical equipment report until the issue is resolved. This will also be discussed at the EHSC meeting to all members.

3. The hospital manages medical equipment risks - EC.02.04.01 EP1
   a. The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment. Tri-City Healthcare District utilizes a capital committee to select and assure the proper equipment is selected. The Capital Committee is made up of (at a minimum) Information Technology, Clinical Engineering, Nursing, Facility Management, Finance and Materials Management.
4. The hospital manages medical equipment risks - EC.02.04.01 EP2
   a. The hospital maintains a written inventory of all medical equipment. Tri-City Healthcare District maintains an electronic and written inventory of all medical equipment. This includes all Critical/High Risk equipment. The Manager of Clinical Engineering evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
   b. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
   c. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.
5. The hospital manages medical equipment risks - EC.02.04.01 EP3
   a. The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
      i. Note: High-risk medical equipment includes life-support equipment. The Manager of Clinical Engineering identifies the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment. Critical/High Risk equipment is identified and scheduled according to manufacturer recommendations. They are tracked using IDesk.
   b. Potential activities selected to ensure reliable performance include:
      i. Predictive maintenance based on manufacturer's recommendation.
      ii. Reliability-centered maintenance based on equipment history.
      iii. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity.
   c. Tri-City Healthcare District's Clinical Engineering Department follows manufacturer's recommendations for predictive (scheduled) maintenance including frequency and task (or the activity that requires MORE frequent inspections). Any changes of maintenance strategy and specific tasks shall be based on the experience accumulated locally or elsewhere, upon approval of the Environment of Care/Safety Committee or appropriate hospital authority.
6. The hospital manages medical equipment risks - EC.02.04.01 EP4
   a. The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM)

program. The Manager of Clinical Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.

b. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk. The Clinical Engineering Technicians perform assigned work orders and review prior to filing. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.

c. In addition, other departments manage performance testing and daily user maintenance of sterilizers.

7. The hospital manages medical equipment risks - EC.02.04.01 EP5
   a. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:
      i. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturer recommendations, or otherwise establishes more stringent maintenance requirements.
      ii. Medical laser devices.
      iii. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes).
      iv. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence:
         1) Records provided by the hospital's contractors.
         2) Information made public by nationally recognized sources.
         3) Records of the hospital's experience over time.
   b. The Manager of Clinical Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, and can be more often based on risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.
   c. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. The Manager of Clinical Engineering manages the work order generation and completion process via IDesk.
8. The hospital manages medical equipment risks - EC.02.04.01 EP6
   a. A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:
      i. How the equipment is used, including the seriousness and prevalence of harm during normal use.
      ii. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm.
      iii. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions.
      iv. Incident history of identical or similar equipment.
      v. Maintenance requirements of the equipment.
   b. The Manager of Clinical Engineering assists in the development of written

procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

c. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

d. Each department leader maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

e. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

9. The hospital manages medical equipment risks - EC.02.04.01 EP7

a. The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. The Manager of Clinical Engineering will bring any alternative equipment maintenance programs to the Environmental Health & Safety Committee for approval before using the alternative measures. There are no alternative maintenance programs currently being used.

10. The hospital manages medical equipment risks - EC.02.04.01 EP8

a. The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager is responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990. The Risk Manager collects information about potentially reportable events through the incident reporting and investigation process. The Risk Manager and appropriate clinical staff conduct investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration. Clinical Engineering will help in the investigation only when instructed by Risk Management.

b. The Risk Manager uses the Sentinel Event Process to investigate and document reportable incidents. The Risk Manager reports for the Environmental Health & Safety Committee on those incidents determined to be reportable. The Risk Manager is also responsible for completing all reports and handling other communications with medical equipment manufacturers and the FDA required by the Safe Medical Devices Act.

c. Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

11. The hospital manages medical equipment risks - EC.02.04.01 EP9

a. The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. The Manager of Clinical Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

b. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate

administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

c. Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

d. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

12. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP1

a. Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. (See also EC.02.04.01, EP 2). The Clinical Engineering staff will test all medical equipment on the inventory before initial usage and perform safety, operational, and functional checks. The inventory includes, equipment owned by Tri-City Healthcare District, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review. The Manager of Clinical Engineering manages the program of scheduled inspection and maintenance.

13. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP2

a. The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. (See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2). The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Critical/High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 100%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the Clinical Engineering Department for review.

14. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP3

a. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. The Manager of Clinical Engineering assures that scheduled testing (inspects, tests and maintains) of all Non Critical/Non High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 95%, the Manager of Clinical Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the Clinical Engineering Department for review.

15. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP4

a. The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. The Manager of Clinical Engineering is responsible for the maintenance and documentation of maintenance of all types of sterilizers used at Tri-City Healthcare District. Maintenance documentation to include SMs are maintained in IDesk (the Clinical Engineering Medical Equipment Database) and filed into the equipment file for review.

b. Records of load testing (performance) and regular user maintenance are maintained by Sterile Processing Department (SPD) and Perioperative Services Department, respectively.

16. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP5

a. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. The Manager of

Clinical Engineering is responsible for managing the service and maintenance of the dialysis units performed by Fresenius. The service maintenance records are also entered into IDesk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.

b. Engineering is responsible for managing the chemical and biological testing of water used in hemodialysis at Tri-City Healthcare District by Fresenius. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis storage room for review.

17. The hospital inspects, tests, and maintains medical equipment - EC.02.04.03 EP14
    a. Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. The Manager of Clinical Engineering assures that scheduled inspecting, testing, and calibrating (for the service and Scheduled Maintenance) of the Nuclear Medicine Camera and related equipment is performed in a timely manner at least annually. The service maintenance records are also entered into I-Desk the Clinical Engineering shop medical equipment database and filed into the equipment file for review.
18. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP1
    a. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
        i. Medical or laboratory equipment management problems, failures, and use errors
            1) Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
            2) Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report. All use errors will have in-service education and follow-up.
19. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP10
    a. Based on its process (es), the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also EC.04.01.03, EP 1) Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by Clinical Engineering on the EHSC report.
20. The hospital collects information to monitor conditions in the environment. EC.04.01.01 EP12
    a. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. (See also EC.04.01.03, EP 1).Clinical Engineering participates on the multi-disciplinary team which conducts environmental safety tours every 6-months in patient care areas and annually in non-patient care areas at Tri-City Healthcare District .
21. The hospital collects information to monitor conditions in the environment - EC.04.01.01 EP15
    a. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. On an annual basis, Manager of Clinical Engineering evaluates the objectives, scope, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at Tri-City Healthcare District. The basis for the evaluation will include but not be limited to the medical equipment performance standards and the EHSC Committee reports on medical equipment issues (supported

from IDesk). The goal of the annual evaluation is to continually improve processes and outcomes to improve the patient experience.

22. The hospital addresses NPSG.06.01.01 - Improve the safety of clinical alarm systems. (EP 1-3 are completed) (EP 4-5 will be accomplished in 2015)
    a. EP 1 - Leaders establish alarm safety as a hospital priority.
    b. EP 2 - Prepare an annual inventory of alarms used in the hospital and identify the default alarm settings. (For more information, refer to Standard EC.02.04.01)
    c. EP 3 - Based on the annual inventory, identify the most important alarms to manage.
    d. EP 4 - Establish policies and procedures for managing the alarms identified in EP 3 above that at a minimum address the following:
        i. Whether specific alarms are needed or unnecessarily contribute to safety concerns.
        ii. When alarms can be disabled.
        iii. When alarm parameters can be changed.
        iv. Who in the organization has the authority to make decisions about disabling alarms and changing alarm parameters.
        v. Monitoring and responding to alarms.
        vi. Checking individual alarms for accurate settings, proper operation, and detectability.
    e. EP 5 - Educate staff about alarm policies and procedures.

G. **INFECTION CONTROL**

1. Clinical Engineering staff will observe the hospitals infection-control policies and procedures, including current CDC hand hygiene guidelines, in order to minimize the risk of cross-contamination to patients and clinicians. In addition, Clinical Engineering employees are required to follow the blood borne pathogens exposure control plan (including training, universal precautions, engineering and safe work practices, personal protective equipment usage, and post-exposure evaluation and follow-up) developed by Aramark Healthcare Technologies as required by OSHA per 29 CFR 1910.1030.

H. **PATIENT INFORMATION PRIVACY (HIPAA):**

1. As a service provider, Clinical Engineering staff do not use or disclose protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 – HIPAA, specifically the Standards for Privacy of Individually Identifiable Health Information. Any disclosure of protected health information to Clinical Engineering staff that occurs in the performance of their duties (such as what may occur while repairing a piece of medical equipment) is limited in nature, occurs as a by-product of the maintenance duties, and cannot be reasonably prevented. Such disclosures are incidental and permitted by the HIPAA Privacy Rule (45 CFR 164.502(a)(1)).
2. On the other hand, Clinical Engineering staff shall follow policies and procedures established by client to protect PHI, including attending required training and assisting clients in identifying privacy risks and practicing risk reduction measures. Specifically, the Technology Managers and CE staff is instructed to:
    a. Assist in identifying and recommending preventive measures for PHI theft risks for medical devices that are exposed to non-authorized employees, patients and visitors.
    b. Work with the Information Technology department to remove all PHI from equipment that is sent out for repair or disposal.
    c. Not use or disclose any information (oral, transmitted, or recorded in any form or medium) that relates to the health (past, present, or future) of or provision of healthcare to an individual.

I. **EMERGENCY PREPAREDNESS AND MANAGEMENT:**

1. Clinical Engineering staff will observe the client's emergency preparedness and management

policies and procedures in order to provide care to the population served by the client in the case of local, regional, and national emergencies.

J. **GOALS AND OJECTIVES FOR FY 17:**

1. **Assess the entire inventory of medical scales throughout the organization for the ability to locked-down the scale to Kilograms only (not able to readout in pounds). Scales where the ability to lockdown is not an option will have a visual reminder sticker added to the front of the device to alert care providers of the risk and to ensure that kilograms are always used for patient safety. Measurement will be the total number of hospital scales/number of scales locked-down to Kg. only and/or labeled with the warning to use Kg. only.**

~~J.~~2. **Increase use of DEFECTIVE stickers on medical devices in need of repairs, by creating a schedule of rounding of all departments and providing on-the-spot education to management and frontline staff. Measurement will be to have 90% or greater of medical devices in need of repair to have the proper use of a defective sticker when sent down to Bio-Med.**

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Safety Management

SUBJECT: Safety Plan

ISSUE DATE: 11/87
REVIEW DATE(S): 06/08, 06/12
REVISION DATE(S): 05/96, 06/97, 07/00, 03/11

Department Approval:	**05/15**
Environmental Health and Safety Committee Approval:	**06/15**
Professional Affairs Committee Approval:	**~~06/15~~01/17**
Board of Directors Approval:	**06/15**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique risks to the patients served, the employees and medical staff who use and manage it, and to others who enter the environment. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by Tri-City Healthcare District.
2. The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that Tri-City Healthcare District has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other individuals, coming to the organization's facilities. The management plan and the environmental management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the Medical Center and all offsite clinics and care sites owned and operated by Tri-City Healthcare District. The Management Plan for Environmental Safety and associated polices extends to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of Tri-City Healthcare District. The plan also affects all staff, volunteers, medical staff and associates including contracted services of Tri-City Healthcare District.

B. **PRINCIPLES:**

1. The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.
2. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.
3. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

C. **OBJECTIVES**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of Tri-City Healthcare District.
2. Perform additional risk assessments when changes involving these issues occur.
3. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
4. Make changes in the procedures and controls to address identified root causes of incidents.
5. Conduct environmental "EOC" rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
6. Present quarterly reports of EC management activities to the environmental Health & Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.
7. Assure that all departments have current organization-wide and department specific procedures and controls designed to manage identified risks.
8. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.
9. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.
10. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.
11. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Safety (Safety Officer), Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
2. The Environmental Safety Leadership Team coordinates the development of reports to the Environmental Health & Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
3. The Environmental Health & Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Environmental Health & Safety Committee are appointed by the Committee Chair. The Environmental Health & Safety Committee meets a minimum of four (4) times per year. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.
4. The Committee assigns individuals or groups responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

5. Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality Improvement, Human Resources, Senior Administration, Bio-Medical Services, Education, Medical Staff, Physician representation, Infection Control and others as deemed appropriate.
6. The Board of Directors of Tri-City Healthcare District receives regular reports of the activities of the environmental safety program from the Environmental Health & Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board collaborates with the CEO and other senior leadership to assure budget and staffing resources are available to support the environmental safety program.
7. The CEO or designee of Tri-City Healthcare District receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.
8. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.
9. The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.
10. Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.
11. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:

1. Appointment of Environmental Safety Leadership (EC.01.01.01 EP1)
   a. The CEO appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The Environmental Safety Leadership Team (ESLT) includes the Director of Safety (Safety Officer), Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering.
   b. The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.
   c. The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of Tri-City Healthcare District.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for Tri-City Healthcare District that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS)

all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.

b. The Immediate Threat Procedure is included in the Emergency Operations Plan. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the plan is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.

c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.

3. Environmental Safety Management Plan (EC.01.01.01 EP3)
   a. The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of Tri-City Healthcare District.
4. The hospital identifies safety risks associated with the environment of care (EC.01.02.01 EP1)
   a. The ESLT of Tri-City Healthcare District performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental "EOC" rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts, **CDPH All Facilities Letters (AFLs), Cal/OSHA standards,** and FDA product recall notices.
   b. The ESLT coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.
5. The hospital takes action to minimize or eliminate identified safety risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in

services occur, when new technology or space is acquired, and at least every three years.

d. The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.

7. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   a. The Director of Engineering (Facilities Management) is responsible for managing the appearance and safety of the hospital grounds. In addition, the Director of Engineering is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.
   b. The Director of Engineering (Facilities Management) is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.
8. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   a. The Director of Safety and the Director of Materials Management coordinate a product safety recall system. Tri-City Healthcare District utilizes the NRAC E-Class system that is designed to quickly assess safety recall notices; to respond to those that affect Tri-City Healthcare District; and to assure all active safety recalls are completed in a timely manner.
   b. A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from Tri-City Healthcare District is presented to the Environmental Health & Safety Committee by the Director of Safety.
9. The hospital prohibits smoking (EC.02.01.03 EP1 & EP2)
   a. Tri-City Healthcare District has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (*ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor producing devices)* in any hospital building or grounds by all, including staff, visitors and patients.
   b. Tri-City Healthcare District has identified alternatives to tobacco products that are offered to all. Tri-City Healthcare District has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost.
10. The hospital takes action to maintain compliance with its smoking policy (EC.02.01.03 EP6)
    a. The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.
11. The hospital monitors conditions in the environment (EC.04.01.01 EP1 - EP11)
    a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety (Safety Officer) works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
    b. Incident reports are completed by a staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health & Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer provides summary information related to incidents to

the CEO and other leaders, including the Board of Directors, as appropriate.

d. The Safety Officer coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of Tri-City Healthcare District.

e. The Environmental Health & Safety Committee and the Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

f. The Chairperson of the Environmental Health & Safety Committee prepares quarterly reports to the leadership of Tri-City Healthcare District. The quarterly reports summarizekey issues reported to the **EHSC & PSC** ~~C~~committees with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out. **Semi-Annual reports are provided to the Board of Directors related to EC.**

12. Environmental tours are conducted every six months in patient care areas (EC.04.01.01 EP12)
    a. Environmental "EOC" rounds at Tri-City Healthcare District are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every six months. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
    c. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
13. Environmental tours are conducted annually in non-patient care areas (EC.04.01.01 EP13)
    a. Environmental "EOC "rounds at Tri-City Healthcare District are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
14. The hospital uses its tours to identify deficiencies, hazards, and unsafe practices (EC.04.01.01 EP14)
    a. The ESLT manages a process of environmental "EOC" rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.
    b. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
15. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Director of Safety (Safety Officer) coordinates the annual evaluation of the management plans associated with the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately

represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the Environmental Health & Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.
d. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.
e. The results of the annual evaluation are presented to the Environmental Health & Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.
f. The annual evaluation is distributed to the Chief Executive Officer, Board of Directors, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

16. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health & Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.
    b. Each time a need for improvement is identified the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the quality improvement program, and the patient safety program.
17. Improving the Environment (EC.04.01.05 EP1 – EP 3)
    a. When the leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the Environmental Health & Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health & Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health & Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.
18. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 & EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual EOC training is provided and documented via NetLearning.
    c. The Human Resources Department with participation from the Education Department coordinates the general New Employee Orientation (NEO) program. New staff

members are required to attend the NEO program within 30 days of their date of employment. The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the EC managers, department leaders, the Director of Risk Management/Quality, Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs.The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

f. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health & Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

~~E.~~ F. GOALS/OBJECTIVES FOR FY17:

~~19.~~**1. Create a Workplace Violence Prevention (WPV) Committee to address the new 2016/2017 Cal/OSHA WPV prevention standards. Measurement of success will be the creation of the committee, regularly attended meetings and a plan in place to meet the requirements within the allotted timeframe provided by Cal/OSHA.**

2. Complete WPV risk assessments for all departments, services throughout the medical center and off-site locations.

~~F.~~G. RELATED DOCUMENTS:

1. Administrative Policy - Smoke Free Environment #205

~~G.~~H. REFERENCES:

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 9/95

SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan

REVISION DATE: 9/01; 9/02; 10/03; 10/06; 10/08, 7/09; 10/09; 7/11; 8/14

Infection Control Department Approval:	~~10/15~~10/16
Infection Control Committee Approval:	~~10/15~~10/16
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/15~~10/16
Professional Affairs Committee Approval:	~~01/16~~01/17
Board of Directors Approval:	01/16

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN INTRODUCTION:**

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration and the Centers for Disease Control and Prevention have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Medical Center to provide care to patients with ATD's with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Source Control Procedures including cough etiquette / respiratory hygiene.
   b. Implementation of an effective triage system and early identification of suspects and active cases
   c. Engineering control measures
   d. Respiratory protection programs
   e. Education and training of employees
   f. Evaluation and treatment of employees exposed to ATD's
   g. Protection of patients, employees and visitors from exposure to ATD's. These include:
      i. Pathogens requiring Airborne Precautions;
         1) Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/Bacillus anthracis
         2) Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
         3) Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
         4) Measles (rubeola)/Measles virus
         5) Monkeypox/Monkeypox virus
         6) Novel or unknown pathogens
         7) Severe acute respiratory syndrome (SARS)/SARS-associated coronavirus (SARS-CoV)
         8) Smallpox (variola)/Varioloa virus (see vaccinia for management of vaccinated persons)

9) Tuberculosis (TB)/Mycobacterium tuberculosis -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
   a) Any other disease for which the CDC or CDHS recommends airborne infection isolation

ii. **Diseases requiring Droplet Precautions;**

1) Diphtheria/Corynebacterium diphtheriae – pharyngeal
2) Epiglottitis, due to Haemophilus influenzae type b
3) Group A Streptococcal (GAS) disease (strep throat, necrotizing fasciitis, impetigo)/Group A streptococcus
4) Haemophilus influenzae Serotype b (Hib) disease/Haemophilus influenzae serotype b -- infants and children
5) Influenza, human (typical seasonal variations)/influenza viruses
6) Meningitis caused by the following organisms:
   a) Haemophilus influenzae, type b known or suspected
   b) Neisseria meningitidis (meningococcal) known or suspected
7) Meningococcal disease/Neisseria meningitidis: sepsis, pneumonia (see also meningitis)
8) Mumps (infectious parotitis)/Mumps virus
9) Mycoplasmal pneumonia/Mycoplasma pneumoniae
10) Parvovirus B19 infection (erythema infectiosum, fifth disease)/Parvovirus B19
11) Pertussis (whooping cough)/Bordetella pertussis
12) Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
13) Pneumonia caused by the following organisms:
   a) Adenovirus
   b) Chlamydia pneumoniae
   c) Mycoplasma pneumoniae
      i) Neisseria meningitidis
   d) Streptococcus pneumoniae (use droplet precautions if evidence of transmission within a patient care unit or facility)
14) Pneumonic plague/Yersinia pestis
15) Rubella virus infection (German measles) (also see congenital rubella)/Rubella virus
16) Scarlet fever in infants and young children/Group A streptococcus,
17) Serious invasive disease
18) Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses, and Hantaviruses

iii. Ebola disease: Special considerations: Please refer to Tri City Medical Center Ebola Plan for management of a patient with confirmed or suspected Ebola.

1) Patients are screened at Triage and/or admission to the facility
2) place patient in negative pressure room C26
3) Patients without symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. Full face shield with surgical N95 respirator or higher.
4) Patients with symptoms of bleeding, vomiting, diarrhea or clinical condition that may warrant invasive or aerosol-generating procedures or overall worsening of symptoms: must wear Extended PPE (Covers all surfaces of the body including head and neck, coverings for the eyes, mouth, nose and skin). The hair must be completely enclosed. PAPR

with full cowl or hood.

5) PAPR with extended PPE should be used prior to entering a patient's room with suspected or confirmed Ebola.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the plan; reporting of suspected and diagnosed cases of ATD's and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.
   b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.
   c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATD's and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling health care workers who have active ATD's. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.
   d. Department Directors are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; notification of the Infection Preventionist and Facilities Management when active TB patients or patients with other ATD's are admitted to their area.
   e. Administrative Supervisor is responsible for implementation of the TB control plan in the hospital during the hours of 1600-0800 and on weekends and holidays; and overseeing the reporting and discharge of suspected or confirmed cases of ATD or Tuberculosis on weekends and holidays.
   f. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATD's.
   g. The Director of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATD's.
   h. The Facilities Director is responsible for monitoring and verifying ~~air changes and~~ air pressures daily on Airborne Infection isolation rooms, when in use, and reporting of air changes and air pressures to the Infection control and Safety committees annually.
   i. The Director of Pulmonary Services is responsible for developing, implementing and monitoring procedures for high-hazard procedures.
   j. The **Facilities Directo**~~Director of Engineering~~ is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.
   k. Microbiology Supervisor is responsible for the notification of the local health authority according to California and Federal regulations of ATD's and TB. The Employees are responsible for early identification of suspects and active cases of ATD's and TB; early

implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; reporting of cases to the Infection Preventionist and/or the Public Health Nurse; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review report.

l. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.
   i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.
   ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.
   iii. Treat all highly suspected tuberculosis cases with antituberculosis medications pending sputum results.
   iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.
   v. Implement control measures when ATD is suspected.

E. **AVAILABILITY OF THE PLAN:**

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual in every department. OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. **FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:**

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
   a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
   b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
   c. The final and least effective control is the use of respiratory protection.

G. **TUBERCULOSIS RISK ASSESSMENT:**

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
   a. Community TB profile from public health department data
   b. Number of infectious TB patients treated in outpatient and inpatient areas.
   c. Drug susceptibility patterns of TB patients

d. Analysis of healthcare workers PPD test results by area
e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
f. Observation of practice and review of engineering controls.

2. Considerations for determining the hospital's risk classification will be based on the following:

VERY LOW RISK	There are no TB patients admitted to the facility during the preceding year
LOW RISK	The employee PPD conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis Fewer than 6 patients were admitted to area during the preceding year There is no evidence of person-to-person transmission No clusters of HCW PPD conversion
INTERMEDIATE RISK	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
HIGH RISK	PPD conversion rate is higher in areas without occupational exposure to Tuberculosis. Clusters of HCW PPD conversion. Evidence of person-to-person transmission. More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current **or past justice involved** ~~or past prison inmate~~, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejunoileal bypass surgery, >10% below body wt, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases. See Appendices A and B for a flow cart and sample questionnaire.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff shall obtain HEPA recirculator from the Engineering department to enhance circulation in the exam or treatment room to be used by the patient. Contact Engineering for placement assistance.

Please note: The patient must be placed in an AIIR room within 5 hours of identification.

a. HCW wear N95 particulate respirators and visitors wear surgical masks when entering this area.
b. If the patient is suspected or known to have infectious TB, the room must remain vacant for one hour after the patient leaves. The door is to remain closed and the filter running.
c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.

7. For off-site areas, the patient will be asked to wear a mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected Pulmonary or Laryngeal TB might require hospitalization to control the spread of infection. See Page 10 for algorithm.
   a. Emergency Department rooms should remain closed for 30 minutes after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.

H. MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:

1. Health Care Workers who are the first points of contact should ask questions that will facilitate identification of patients with signs and symptoms suggestive of TB. See the Admission Database screening questions.
2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an Airborne Illness Isolation Room (AIIR) (i.e. negative pressure room: C-26, 143, 243, 443, 287, 387, 487,200 and ~~Forensic~~**Progressive Care Unit (PCU)** Rooms 301, 312 and 326). The door must be closed and the HEPA filter running. Post the Airborne Precautions sign, outside the room.
   a. If a designated room is not available, notify the charge nurse and the bed coordinator of the need for an Airborne Precautions room. Remove any roommates and call Engineering for the HEPA filter. Keep the door closed and post the Airborne Precautions sign. HCW wear N95 particulate respirators and visitors wear surgical masks when entering this room.
   b. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
3. Reporting:
   a. The Unit Secretary notifies Engineering (by placing a worker order) and the Infection Control office that an Airborne Precautions room is in use for tuberculosis.
   b. The charge or patient's nurse must notify the Infection Preventionist of the patient's name, medical record and room number. Phone call is used.
   c. On weekends and holidays, the charge nurse or the primary nurse will notify the Public Health Nurse by calling cell phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
   d. Laboratory Results: Hospitals and health care providers are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
   e. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures is sent to the Public Health.
   f. The Infection Preventionist or designee is responsible for reporting to public health. Tuberculosis (TB) Program Nurses are available 8:00 a.m. to 5:00 p.m., 7 days a week and all holidays on cell phone number (619) 540-0194 TB control does not have personnel available between the hours of 5:00 p.m. and 8:00 a.m. Persons with routine questions or questions about TB exposure should call phone number (619) 692-8610

after 8:00 a.m. on the following day.

g. Person wanting to report a case of TB after 5 P.M. should do one of the following:
   i. Call pager (619) 540-0194 after 8:00 a.m. the following day to report directly to TB RN if they feel there is urgency about reporting; or
   ii. Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.

h. Person requesting Discharge Approval should:
   i. Contact TB RN between 8:00 a.m. and 5:00 p.m.

i. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5 P.M., should do the following:
   i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.
   ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB RN on phone number (619) 692-8610 after 8:00 a.m. on the following day.

j. Persons calling about patients who are leaving against medical advice (AMA):
   i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)
   ii. Call intake RN between 8 am and 5 pm; after hours call 8:00 a.m. the next day
      1) Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for the report form.

4. Health-care workers (fit-tested and approved for use) will wear an N-95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health section.
5. The nurse will initiate the Tuberculosis Management protocol and the Communicable Disease teaching protocol.
6. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as are adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
7. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and the areas are less crowded.
8. Limit the number of persons entering an isolation room to a minimum. All visitors (except HCW who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
9. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
10. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
    a. The patient is in an Airborne Precautions room.
    b. The portable air filtration system has been set-up in a regular room.
11. Health care workers must wear respiratory protection (Powered Air Purifying Respirator- PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who may have infectious Tuberculosis. See high hazard procedures.
12. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If

transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until outside the hospital.

13. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Healthcare workers entering the room before the 1.5 hours are over will wear an N95 respirator (see high hazard procedures)
14. Bronchoscopy considerations
    a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever a suspect case is performed. Respiratory protection will be worn. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:

1. Operating Rooms
    a. Elective procedures on patients with tuberculosis should be delayed until the patient is no longer infectious.
    b. If procedures must be performed, they should be done in OR rooms ~~with anterooms~~ with door closed and traffic at a minimum.
    c. Personnel present when operative procedures are performed on patients who have infectious tuberculosis should wear respiratory protection rather than standard surgical masks alone. Valved or positive-pressure respirators are not appropriate for use during procedures requiring surgical masks.
    d. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary sites.
    e. A bacterial filter placed on the patient endotracheal tube or at the expiratory side of the breathing circuit of the anesthesia machine may be useful in reducing the risk of contamination of anesthesia equipment or discharge of tubercle bacilli into the ambient air when anesthesia is being administered to a patient with possible tuberculosis.
    f. The pulmonary TB patient should be monitored during recovery in an individual room meeting Airborne Isolation room ventilation requirements.
    g. Surgery Suites should be closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
2. Autopsy Room
    a. Due to the probability of the presence of infectious aerosols, autopsy rooms should be at negative pressure with respect to adjacent areas, with room air exhausted directly to the outside of the building. ASHRAE recommends that autopsy rooms have ventilation that provides 12 total **air changes per hour** (ACH).
    b. Personnel performing autopsies on patients who may have had tuberculosis should wear respiratory protection (see high hazard procedures)
    c. In-duct HEPA filtered air re-circulation or UVGI may be used as a supplement to the recommended ventilation.
    d. The autopsy room should remain closed for one hour after the patient leaves to ensure 99.9% removal of contaminants. Personnel may enter the room before this time has lapsed but must wear an appropriate respirator.
    e. Deaths caused by a known or suspected contagious disease constituting a public health hazard are reportable to the Medical Examiner's Office. Autopsy performed on these cases will be performed by the medical examiner.
3. Home Health Services
    a. HCWs entering the home of a patient with confirmed or suspected TB or ATD should wear respiratory protection.
    b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.

c. Educate patient regarding importance of taking medication (and administering directly observed therapy).
d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.
e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). HCWs will wear respiratory protection during the procedure
f. Specific processes and procedures pertaining to ATD's in the home are found in the Home Health Care policy manual.

J. **DIAGNOSTIC EVALUATION:**

1. Diagnostic evaluation should include the following:
   a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.
   b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.
   c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.
   d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.
   e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL). (See Table 1).This will assist in determining if the patient is infectious. Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.
   f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.
   g. Drug susceptibility should be performed on all initial isolates from patients with TB.
   h. Contact Infection Control at Ext. 5696 or 7410 for the latest recommendations.

K. **AIRBORNE PRECAUTIONS:**

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.
   a. Airborne Precautions can be discontinued:
      i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum AFB smears
      ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL OR when another diagnosis is confirmed
2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or

relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer (This form can be accessed at: http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-273TuberculosisDischargeCarePlan.pdf)

~~1.~~**a.** **Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:**

~~a.~~**i.** **The Department of Health TB Control to the specific county in which the justice involved patient is residing**

~~2.~~**ii.** **The Public Health Department of the prison.**

~~3.~~**2.** Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.

~~4.~~**3.** A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.

~~5.~~**4.** Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.

~~6.~~**5.** Placement into case management (e.g. DOT) or outreach programs of the public health department.

~~7.~~**6.** The charge nurse~~, or~~ shift supervisor**, patients nurse or Case Manager,** will notify the Public Health Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.

i. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194

~~8.~~**7.** Cleaning of the room after a known or suspected TB patient is moved or discharged:

a. The patient is infectious or might be infectious and **was not in a negative pressure** and HEPA filtered room: Post the Airborne Precautions sign and keep the door closed. Call Engineering for a HEPA filter. Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

Area	Length of Time Room is Closed
Orthopedics/Rehab (1N/S)	Two hours
Maternal/Child	Two Hours
South	Two hours
3 N/S	Two hours
Pavilion	One hour
E/W Tower	One hour
Surgery	One hour
Radiology	One hour
Emergency Department	30 minutes
Bronchoscopy area	30 minutes

~~9.~~**8.** The patient is still infectious and **was in a negative pressure room**: keep the Airborne Precautions sign posted, leave the HEPA filter running and close the door for one more hour. Post a sign that specifies this time period. TCMC staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the one-hour

period has ended, discontinue Airborne Precautions.

~~10.~~**9.** The patient is no longer infectious or TB has been ruled out: no special precautions needed. The door may be immediately opened and the room cleaned as usual.

M. **ANNUAL TUBERCULOSIS SCREENING:**

1. Auxiliary and Employees: See the Employee Health section 7.1, TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners.

N. **AEROSOL TRANSMISSIBLE DISEASE CONTRO EXPOSURE DETERMINATION**

1. A list of tall job classifications in which employees have occupational exposure is available in the Infection Control Manual Employee Health Respiratory Protection Program.

O. **ISOLATION PRECAUTIONS**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant Health Care workers (IC.5.2).

P. **HIGH HAZARD PROCEDURES:**

LOCATION	**COMMON HIGH HAZARD PROCEDURES REQUIRING THE USE OF: AN N-95 RESPIRATOR for patients with known or suspected droplet infectious disease POSITIVE AIR PURIFYING RESPIRATOR (PAPR) FOR PATIENTS WITH KNOWN OR SUSPECTED Airborne Infectious Disease**
ACCU, PACU, ED and Bronchoscopy Suite	Intubation and Extubation Sputum Induction Endotracheal & Tracheostomy Tube Care Bronchoscopy
Medical / Surgical Units	Sputum Induction Endotracheal Intubation
Pulmonary Services	Sputum Induction Pulmonary Function Tests Bronchoscopy Aerosolized administration of pentamidine or other medication
Operating Rooms	Intubation and Extubation Bronchoscopy Tracheotomy Thoracotomy Lung Biopsy Endotracheal & Tracheostomy Tube Care
Recovery	Endotracheal & Tracheostomy Tube Care Intubation or Extubation
Pathology	Autopsy

Q. **SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS**

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to

wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."

2. Emergency Department
   a. Engineering Controls during a surge of patients with ATD is addressed in the TCMC Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*.
   b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
   c. Staff wears PAPR's during high hazard procedures (listed above) for disease spread by the airborne route.
   d. N-95 respirators or PAPR's are used during patient contact for diseases spread by airborne route.
   e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
   f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for Airborne Infection Isolation Room (AIIR) C-26.
   g. When room C-26 is not available a private room is used.
   h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
   i. Patients may be cohorted in designated rooms or bays when indicated.
   j. Patients suspected of having ATD's are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
   l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
   m. When used for a patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
   a. Patients who are admitted with airborne transmissible diseases are admitted to AIIR's on nursing units.
   b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions. A TB quicklook is posted outside each AIIR for step by step instructions on initiating and maintaining proper airflow.
   c. Doors are kept closed.
   d. Patients in Droplet precautions do not need AIIR's for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See chart above (section P) for selection on type of respirator.
   e. Portable HEPA filtration units can be used to facilitate AIIR. Engineering installs and maintains these devices. Place a work order for installation and monitoring.
   f. Airborne Infection Isolation rooms shall remain empty with Airborne Precautions sign posted and door closed for designated time (see L.2.a) when a patient with Airborne transmissible disease has occupied the room.
4. Pulmonary Services
   a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
   b. N-95 respirators or PAPR's are used during Bronchoscopy.
   c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically

indicated.

d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The HCW should wear an N-95 or PAPR during this treatment (see high hazard procedures).
e. Bronchoscopy suite will remain closed for the designated time (see L.2.a) when procedure is performed on a patient with known or suspected ATD.
f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.

5. Surgical Services
   a. The Surgical Suite is a positive pressure environment.
   b. Patients in Airborne and Droplet Precautions should have elective procedures delayed for the duration of illness. When this cannot be accomplished, surgery should be scheduled as the last case of the day.
   c. Provide surgical mask for patients during transport.
   d. Expiratory filters can be used for intubated patients during transport.
   e. A portable HEPA unit should be utilized in the OR suite during intubation and extubation to supplement air cleaning but should not be used during surgery. HCW's shall wear N-95 respirator or PAPR See high hazard procedures.
   f. Airborne precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.
   g. Surgical suite shall remain empty for designated time (see L.2.a) with door closed when a procedure has been performed on a patient with known or suspected ATD.
6. Maternal Child Health Services (MCH)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by Airborne Route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery and Post-Partum
      i. Labor rooms may have portable HEPA units installed for mothers who have suspected ATD.
      ii. Healthcare workers follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPR's for Airborne Precautions.
      iii. Rooms 200 and 201 are an AIIR and are used for MCH patients who require Airborne Precautions or need high hazard procedures.
7. Behavioral Health
      i. Patients who develop symptoms of ATD will be assessed by the physician to determine the need for medical intervention.
      ii. Source control will be implemented including masking the patient, use of tissues and hand hygiene.
      iii. If ATD illness is suspected (see list above) the patient will be asked to remain in their room and wear a surgical mask while awaiting admission to the hospital for further treatment.
      iv. If the patient is unable to wear a mask and non-compliant with containing respiratory secretions with tissues. Healthcare workers will wear appropriate PPE based on the transmission of the suspected illness (Droplet or Airborne transmission).
      v. If droplet precautions are indicated (see list above) and the patient is medically stable, the patient may remain on the BHU and Droplet precautions will be instituted and maintained for the duration of illness.
      vi. Airborne precautions cannot be implemented in the BHU. The need for admission to the hospital will be assessed on a case by case basis.

vii. Patients who are identified as needing and AIIR will be transferred within five hours of identification.

8. Laboratory Services
   a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
   b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy
9. Facilities Management Staff
   a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
   b. N-95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.
10. Personal Protective Equipment
   a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
   b. Respiratory Protection including N-95 respirators or PAPR's is required in any hospital location in the following circumstances:
      i. Entering an Airborne Isolation Room occupied by a patient with an airborne transmitted ATD
      ii. Entering an Airborne Precautions room that is occupied or has been occupied within the past hour by a patient with active untreated airborne illness including pulmonary or laryngeal TB.
      iii. Entering a regular room where a patient with active or untreated pulmonary or laryngeal TB is undergoing or has undergone within the past 8 hours any high-hazard medical procedure.
      iv. Providing services that involve the need to be in close prolonged contact with a patient with active untreated airborne transmissible illness including pulmonary or laryngeal TB.
      v. Attending high hazard procedures.
   c. Respirator Shortages
      i. In the event of reported shortages of N-95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):
         1) TCMC will maintain a cache of N-95 respirators in accordance with the disaster plan.
         2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
         3) According to available stock, N-95 respirators will be prioritized for distribution to Pulmonary Services ICU, and Emergency Department for use in high hazard procedures.
         4) Re-use of N-95 respirators for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
         5) Reuse of N-95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
            a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD .
            b) The respirator integrity remains intact
            c) During the care of intubated and ventilated patients (closed circuit suction systems).
      ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N-95)

the following steps may be considered:

1) Prioritize available N-95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N-95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPR's may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N-95 respirators, surgical masks will be provide to the employee

iii. Positive Air Purifying Respirators (PAPR's)

1) PAPR's used for bronchoscopy are maintained in Respiratory Care Department
2) SPD stores and maintains all other PAPR's
3) Units are cleaned, disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used

11. Admissions and transfers of patients with known or suspected Airborne transmissible ATD.
    a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
    b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
    c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N-95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
12. Influenza Season
    a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty in the hospital. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
    b. The enforcement dates are subject to change based on the recommendations of the hospital's Infection Control Committee.
    c. Non-compliance with this requirement is subject discipline as outlined in the hospital's Human Resources policy.

R. **MEDICAL SERVICES**

1. Vaccinations are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATD's.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies

S. **TRAINING**

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
   a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

T. **REVIEW SCHEDULE**

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected

U. **RELATED DOCUMENTS:**

1. Infection Control **Policy**~~Manual~~: ~~Infection Prevention and Control~~ Risk **A**~~a~~ssessment and Surveillance Plan ~~IC .2~~
2. Infection Control Manual: Epidemiologic Investigation of a Suspected Outbreak ~~IC .3~~
3. Infection Control Manual: Healthcare Associated Infections, Defined ~~IC .4~~
4. Reducing Facility Acquired Infections ~~IC. 13~~
5. Employee Health and Wellness Manual: Immunization
6. Employee Health and Wellness Manual: Employee Health: Respiratory Protection

V. **REFERENCES:**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003.
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance www.cdc.gov
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. Retrieved on September 28, 2015 from: http://www.cdph.ca.gov/programs/ohb/Documents/HCResp-ATD-RespSelectGuide.pdf
5. California Department of Public Health (2015, January 20). Interim Guidance on Personal Protective Equipment (PPE) to be used by Healthcare Workers in the Inpatient Hospital Setting during Management of Patients with Suspected or Confirmed Ebola Virus Disease in California. Retrieved from: http://www.cdph.ca.gov/programs/cder/Documents/CDPH%20-%20PPE%20Guidance%20for%20Management%20of%20Ebola%20Patients%20in%20an%20Inpatient%20Setting%20-FINAL%201-20-2015%20POSTED.pdf
6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
7. OSHA Directives CPL 2.106- Enforcement Procedures and Scheduling for Occupational Exposure to Tuberculosis US Department of Health and Human Services. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=DIRECTIVES&p_id=1586&p_text_version=FALSE
8. Cal-OSHA Aerosol Transmissible Diseases Standard, August 5, 2009
9. New Guidelines for Purified Protein Derivative (PPD) Skin Test Interpretation and Treatment Modalities for Tuberculosis Infection. Pulmonary Perspectives, April 2001 Volume 18, Issue 1
10. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.
11. TB Respiratory Protection Program In Health Care Facilities Administrator's Guide U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service Centers for Disease Control and Prevention National Institute for Occupational Safety and Health September 1999

TABLE 1
Criteria for Infectiousness and placement in high risk setting (~~Forensic~~PCU Unit only)

CATEGORY	SETTING	CRITERIA
TB suspect - Not on treatment for suspect active TB	~~Forensic Unit~~**PCU**	3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative
TB case or suspect on treatment for active TB -AFB smear positive -No risk factor for MDR-TB	~~Forensic Unit~~**PCU**	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement
TB case or suspect on treatment for TB -AFB smear negative X3 -No risk factor for MDR-TB	~~Forensic Unit~~**PCU**	At least 5 daily doses of treatment for TB taken and tolerated
TB case or suspect on treatment for TB -At increased risk for MDR-TB	~~Forensic Unit~~**PCU**	1. Obtain direct genetic test, if available, for Rifampin resistance 2. If direct genetic test not available, while phenotypic DST for Rifampin is pending, other criteria for patients with known MDR-TB, or criteria for patients not at increased risk of MDR-TB, or criteria for patients not at increased risk of MRD-TB may be applied, at the discretion of the local TB controller
Known MDR-TB case	~~Forensic Unit~~**PCU**	1. 3 consecutive respiratory specimens, including one early AM or induced sputum, or BAL, collected at least 8 hours apart, are AFB smear negative 2. At least 14 daily doses of treatment for TB, preferably by directly observed therapy (DOT), taken and tolerated; and 3. Clinical improvement 4. At least 2 consecutive negative sputum cultures without a subsequent positive culture

Reference:

CDPH/CTCA (2005). Guidelines for the assessment of tuberculosis patient infectiousness and placement in high and low risk settings. California Department of Public Health and California Tuberculosis Controllers Association.

EMERGENCY DEPARTMENT TUBERCULOSIS DECISION TREE
APPENDIX A

Patient has signs and symptoms or chest x-ray compatible with TB

AND

Unstable housing or resident in a group setting
OR
Acutely ill or needing invasive diagnostic or therapeutic procedure
OR
Strong likelihood that patient will **not** follow-up with outpatient work-up

↓

Admit to Medicine and place on Airborne Precautions
For assistance
contact the TB Control Program or Infection Control at the numbers below.

AND

Stable, non-group housing
AND
Not acutely ill or needing invasive diagnostic or therapeutic procedure
AND
Strong likelihood that patient will follow-up with outpatient work-up

↓

Discharge the patient with a written plan for outpatient care & surgical masks to wear
AND
Instruct the patient to remain on home isolation[1] until infectiousness is ruled out
AND
Alert the TB Control Program ASAP, but no longer than 24 hours.

[1]Home isolation: Stay alone in a separate room with the door closed, as much as possible. Keep a window slightly open at all times. When alone in this room, you do not need to wear a mask. Please be sure to sleep and eat while alone in this room. Persons entering this room need to wear a mask. If you leave the room, you need to wear a mask. For example, when you use a shared bathroom or go to the doctor's office wear a mask.

TB Control in San Diego County is available 7 days a week from 0800 to 1700 only. Weekdays call TB Control at (619) 692-8610 and on Weekends and holidays call cell phone number (619) 540-0194 OR Leave a message on the Tuberculosis RN voice mail (619) 692-8610 and your call will be returned on the next working week day. Messages should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information. Also leave a message at TCMC Infection Control: call ext. 7410 or 5696

Tri-City Medical Center

Welcome to Tri-City Medical Center. Our commitment to you, our patient, is to give you the highest quality care. In order to do that, we need your help. Please answer the questions below, so that we can take better care of you. If there are any questions you do not understand, please ask for help from one of our employees.

If you are filling this out for someone else, please answer the questions as if you were that person.

Medical Record Number _____

Name _____ Date _____
(Please Print Clearly)

1. Have you had any of these problems?

	Please circle your answer	
Cough longer than 3 weeks?	Yes	No
Do you cough up blood?	Yes	No
Do you have night sweats?	Yes	No
Have you lost weight?	Yes	No
If you have lost weight- how much?		
Have you lost your appetite?	Yes	No
Do you have a fever	Yes	No

2. Have you ever had?

	Please circle your answer	
A positive skin test for TB?	Yes	No
Active Tuberculosis?	Yes	No
Lived or worked with someone who had TB?	Yes	No
Have you lived outside the United States for longer than one month?	Yes	No

3. What country were you born in? _____

4. Have you had?

	Please circle your answer	
Severe coughing spasms, that interfere with eating, drinking and breathing?	Yes	No
Fever with painful swollen salivary glands on one side or both sides of your face under your jaw?	Yes	No
Fever with chills, cough, runny nose watery eyes and unexplained diffuse rash or blister type skin rash?	Yes	No
Fever with headache, stiff neck, or changes in your mental status.	Yes	No

THANK YOU

Tri-City Medical Center

Bienvenido/a a Tri-City Medical Center. Nuestro compromiso con usted, como paciente nuestro/a, es ofrecerle una atención médica de la más alta calidad. Para lograr esto, necesitamos su ayuda. Tenga la bondad de contestar las preguntas a continuación, y así le podremos atender mejor. Si hay preguntas que no entiende, pida ayuda a un miembro de nuestro personal.

Si está ayudando a otra persona a llenar este formulario, por favor, conteste las preguntas como si usted fuera la persona a quien ayuda.

Número de historial medico _____

Nombre _____ Fecha _____
(Escriba claramente en letra de molde)

1. ¿Ha tenido usted alguna de las condiciones siguientes?

	Marque sus respuestas con un círculo	
¿Tos durante más de 3 semanas ?	Sí	No
¿Ha expectorado sangre al toser?	Sí	No
¿Ha experimentado usted sudores nocturnos?	Sí	No
¿Ha experimentado pérdida de peso?	Sí	No
Si ha perdido peso, ¿cuánto ha perdido?		
¿Ha experimentado pérdida de su apetito?	Sí	No
¿Tiene usted fiebre?	Sí	No

2. ¿Ha tenido usted alguna vez una de las siguientes condiciones?

	Marque sus respuestas con un círculo	
¿Una reacción positiva en la piel por una prueba de tuberculosis?	Sí	No
¿Ha padecido activamente de tuberculosis?	Sí	No
¿Ha vivido o trabajado con alguien que sufría de tuberculosis?	Sí	No
¿A vivido afvera de los Estodos Unidos por mas de un mes?	Sí	No

3. ¿En qué país nació? _____

4. ¿Ha tenido…

	Marque sus respuestas con un círculo	
¿espasmos de tos graves que le impidan comer, beber o respirar?	Sí	No
¿fiebre con inflamación y dolor en glándulas salivales de uno o ambos lados de su rostro debajo de la mandíbula?	Sí	No
¿fiebre con escalofríos, tos, secreciones nasales, ojos llorosos y erupciones difusas o erupciones con ampollas sin explicación?	Sí	No
¿fiebre con dolor de cabeza, rigidez en el cuello o cambios del estado mental?	Sí	No

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL MANUAL

SUBJECT: Standard and Transmission-Based Precautions

ISSUE DATE: 11/99
REVISION DATE(S): 10/05, 01/11, 09/15

Infection Control Department Approval:	~~07/15~~10/16
Infection Control Committee Approval:	~~07/15~~10/16
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~08/15~~10/16
Professional Affairs Committee Approval:	~~09/15~~01/17
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. The Centers for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of PPE prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. For immunocompromised patients see Patient Care Services (PCS) Neutropenic Precautions
   a. Use Standard Precautions, with emphasis on hand hygiene.
   b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
   c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be **ordered for the patient.**~~written in the physician's order forms.~~
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and **gown**~~apron~~ based upon anticipated contact with infectious materials.
   c. Physicians should be aware of their ~~status in regard to~~ current vaccination **status regarding** (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against **h**~~h~~epatitis B.
3. The role of nurses and other direct care providers is to:
   a. Assure that isolation orders are entered **and proper isolation signage is posted outside of the patients room.**~~.~~
   b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance. **Direct care providers**~~Nurses~~ need to evaluate their interaction with the patient and use barriers

such as masks, eyewear, **and** ~~and~~ gowns~~ and/or aprons~~ based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.

c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.

d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.

e. The nurse **and or caregiver** is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the **Off Unit Transfer/Assessment: Type of Isolation/Precautions in the electronic medical record (EMR)**~~"hand-off communication form" isolation section.~~

4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.

5. All direct care providers who have frequent contact with blood or body fluids should be immunized against **h**~~H~~epatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center.

6. Specimen Labeling

   a. Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients diagnosis. Standard precautions need to be utilized while handling all specimens. (In 1990, the Clinical Laboratory established formal policies requiring that all specimens be handled as if potentially infectious. To place "blood and body fluid precautions" on specimen conveys the notion to others to treat this particular specimen with caution, but other specimen without the labeling need not be handled as carefully. ~~S~~ If needed, it is permissible to note the patient's diagnosis on laboratory requests, pathology requests, radiology request, etc. Please note that it is illegal in the state of California to note a person's HIV status on requests).

7. Handling of soiled linen from patients' rooms

   a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.

8. Dishware and eating utensils

   a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.

9. Disposal of waste from patients' rooms

   a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.

10. All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:

    a. Obtain a red "biohazardous" plastic bag from the soiled utility room.

    b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.

    c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.

    d. All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.

11. Wound Dressings
    a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples of these are IV dressings, trach site dressings, bandaids, **gauze or** ~~or~~ cotton balls used in fingerstick glucose testing,
    b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucus membranes and non-intact skin.
    a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
    a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
    b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
        i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
    c. Gloves
        i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
        ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
        iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
        iv. Decontaminate hands immediately after removing gloves.
    d. Masks, Eye/Face Shields:
        i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Appendix: Standard Precautions: Personal Precautions Equipment Table)
        ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
    e. Gown
        i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
        i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
        ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene

after glove removal

4. Patient Care Equipment
   a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the environment.
   b. Ensure that reusable equipment is properly cleaned **and disinfected** before it is used for the care of another patient.
   c. Single use items should be discarded.
5. Environmental Control
   a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.
6. Safe injection practices – see PCS Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
   a. Use aseptic technique to avoid contamination of sterile injection equipment.
   b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
   c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

D. **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
   a. Types of Transmission-based Precautions:
      i. Airborne Precautions
      ii. Droplet Precautions
      iii. Contact Precautions
   b. **Communicate and n**~~N~~otify receiving department/services if patient requires **T**~~t~~ransmission-based **P**~~p~~recautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
   a. In addition to Standard Precautions, use **A**~~a~~irborne **P**~~p~~recautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.
   d. Mask patients during transport.
4. Contact Precautions
   a. In addition to Standard Precautions, use Contact Precautions for specified patients

known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients environment such as MRSA and VRE. (See Infection Control Policy: **M**~~m~~anagement of **P**~~p~~atient**s** with MDRO's)

b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with infection control staff is advised when there are questions about patient placement.

c. Gloves
   i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails) Don gloves upon entry into the room or cubicle.

d. Gowns
   i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle.
   ii. Remove gown and gloves and observe hand hygiene before leaving the patient-care environment

e. Dedicate the use of non-critical equipment to a single patient, when possible

f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant

g. Patient transport
   i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

E. RELATED DOCUMENTS:

1. PCS Neutropenic Precautions
2. PCS Medication Administration policy
3. Infection Control Policy: ATD: Tuberculosis Control Plan
4. Infection Control Policy: Blood borne Pathogen Exposure Control Plan

F. REFERENCES

1. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing *Transmission of Infectious Agents in Healthcare Settings, June 2007* *http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf*
2. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare Engineering/American Hospital Association; 2004.
3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.

Tri-City Health Care District
Oceanside, California

Infection Control Policy Manual

ISSUE DATE: 9/01	**SUBJECT: Waterborne Illness**
REVISION DATE: 9/04, 10/07, 10/10	~~**POLICY NUMBER: IC.13.1**~~
Infection Control Department Approval:	**10/16**
Infection Control Committee Approval:	**~~10/13~~10/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/13~~10/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	**10/13**

A. **INTRODUCTION**

1. Legionellosis is a collective term describing infection produced by the pathogen Legionella, a bacterium found in water environments. Most hospital hot water systems are colonized with Legionella, which is introduced into institutional water distribution systems from public/municipal water systems (that do not routinely screen water for the presence of Legionella). Since legionellae is chlorine tolerant, it will survive many of the standard municipal water treatment protocols. The transmission of Legionella in healthcare facilities is by the Inhalation of aerosolized water contaminated with Legionella bacteria.

B. **PURPOSE**

1. This plan describes how the organization will establish and maintain a utility systems management program to reduce the potential for organizational-acquired illness related to waterborne illness. The plan provides processes to decrease the risk of transmission through contaminated patient care equipment. Steps for investigation of outbreaks and remediation are outlined if potential nosocomial infections were identified.

C. **SCOPE**

1. This plan applies to all aerosolizing water systems in Tri-City Medical Center (for example: cooling towers, domestic hot water taps, evaporative coolers, and etc.) and to all immunocompromised patients admitted to the hospital.
2. Program Administration
   a. The **Director of Safety/**Environment of Care ~~Officer~~ is responsible for the implementation, maintenance and administration of the **Environmental Health & Safety Committee.**~~JCAHO's Environment of Care Committee~~.
   b. To assist the **Director of Safety/**Environment of Care ~~Officer~~ in carrying out their duties the **Environmental Health & Safety** ~~Environment of Care~~ Committee and following specific people will be contacted as needed.
3. Engineering
4. Infection Control Department
5. Microbiology Laboratory Manager
   a. Engineering is responsible for the following (See Appendix A)
      i. Perform an initial assessment of the environmental risk from the plumbing system. Identify factors with potential to amplify growth of waterborne microorganisms such as the domestic hot water heater, dead legs of low flow conditions, water temperature, and maintenance.
      ii. Perform an initial assessment of the environmental risk from the heating, cooling and humidifying system that produces aerosolized water or involves standing water.

iii. Develop and document maintenance schedules to decrease risk (i.e. drift eliminators, cleaning cooling towers and use of an effective biocide) using recognized experts such ASHE. Infection Control Department is responsible for the assessment of the clinical risk of the organization's patient population including the following: (See Appendix B)

iv. Identify the treatment/care areas for patients at greatest risk of contracting Legionellosis.

b. Ongoing surveillance for facility acquired Legionellosis.

i. Microbiology Laboratory: Preprinted order for bronchoscopy specimen includes include screening legionella.

ii. Laboratory methods used at Tri-City Medical Center for diagnosis of legionella infection include the following

6. Urinary antigen is relatively inexpensive, simple, and rapid.
7. Enzyme-linked immunoassay (EIA)
8. Legionella cultures
   a. **If the culture grows positive for Legionella, our Laboratory will perform serotyping for Legionella species. If it is not serogroup 1, the Laboratory will final the report out as Legionella species, not Legionella pneumophila serogroup 1.** ~~Positive cultures are sent to the Microbial Diseases Laboratory (MDL) of the California DHS for confirmation and serotyping.~~

D. **RISK ASSESSMENT**

1. See Appendix A for a table outlining the environmental assessment.
2. See Appendix B for a table outlining the clinical risk of TCMC's patient population.
3. See Appendix C for a table of remediation water treatment methods.
4. See Appendix D for a Legionella Fact Sheet.

E. **PRIMARY PREVENTION**

1. Develop a management plan as a result of the assessment that includes standard operating procedures (SOP's) for maintenance and operation of water systems
   a. Develop a system to document and log findings as a result of these SOP's such as temperatures, blow down of hot water tanks, cooling tower inspections etc.
   b. Maintenance and audit program for any systems that are currently installed to limit Legionella amplification in aerosolizing systems such as cooling towers and /or potable water treatment systems (e.g. copper silver or chlorine dioxide).
   c. Inspect cooling towers/evaporative coolers to ensure that they are in proper condition and operate as designed. Install drift eliminators.
   d. Use an oxidizing biocide continuously to prevent the formation of biofilms and control biological growth. (E.g. bromine, chlorine, iodine, chlorine dioxide, ozone, etc.) And intermittently a non-oxidizing biocide (e.g. DBNPA, isothiazoline, etc.).
   e. Maintain towers according to manufacturers recommendations. If the tower/cooler is subject to **extended**~~seasonal~~ shutdown, equipment should be cleaned and treated prior to shutdown and again before starting up.
2. Incorporate Infection Control strategies in the facilities patient care policies.
   a. Use sterile water or rinsing nebulization devices and other semi-critical respiratory-care equipment after such items have been cleaned and /or disinfected.
   b. Use sterile water to fill reservoirs of devices used for nebulization.
   c. Use sterile water to flush nasogastric tubes.
   d. Large-volume room air humidifiers use is discouraged and those used are subjected to high-level disinfection daily and filled with sterile water.
   e. Protecting patient-care devices and instruments from inadvertent tap water contamination during room cleaning
3. Remediation (if an outbreak of Legionellosis is suspected or identified)

4. Outbreak is defined as at least one case of laboratory-confirmed case of legionellosis that occur in patients who have been hospitalized continuously for >10 days before the onset of illness and/or a possible case (i.e., laboratory-confirmed infections that occur 2 - 9 days after hospital admission.
5. A multidisciplinary team, comprised of members of the Infection Control and **Environmental Health & Safety Committees** ~~Environment of Care Committees~~ will be utilized to organize the facilities response. A report will be made to the appropriate public health agencies.

Epidemiologic Investigation	Environmental Investigation
Review medical and microbiologic records.	Risk factors among potential environmental exposures (e.g., showers, cooling towers, respiratory-therapy equipment, etc.)
Initiate active surveillance to identify all recent or ongoing cases	Collect water samples from environmental sources implicated by epidemiologic investigation
Develop a line listing of cases by time, place, and person.	Other aerosolized water sources
Determine the type of epidemiologic investigation needed for assessing risk factors. Case-control study - Cohort study	
Gather and analyze epidemiologic information Subtype strains of Legionella spp. cultured from patients & environmental sources Review autopsy records and include autopsy specimens in diagnostic testing	

Control Measures: if water is contaminated with Legionella spp.	Remediation of potable water: in response to identified nosocomial cases
Restrict patients from taking showers and provide clean water for sponge baths	Superheating of water (at least 149oF)
Provide sterile water for drinking, tooth brushing, or for flushing nasogastric tubes.	"Shock" hyperchlorination >10 mg/L of chlorine in water
Remove showerheads and faucet aerators monthly for cleaning.	
Use a 1:100 solution of chlorine bleach to disinfect showerheads and aerators.	
Cooling towers should be designed and constructed so that tower drift is directed away from the hospital's air intake system and the volume or aerosol drift is minimized.	

~~6.~~F. RELATED DOCUMENTS:

~~7.~~1. **Engineering Infection Control: Managing Biological Agents to Prevent Waterborne Illness**~~Reduction of Facility Acquired Infections IC. 13~~
~~8.~~2. **Infection Control Policy:** Surveillance Program ~~IC. 2~~
~~9.~~3. **Infection Control Policy:** Epidemiologic Investigation of a Suspected Outbreak ~~IC. 3~~
~~10.~~ ~~Definitions of Facility Acquired Infections IC. 4~~

~~F.~~G. REFERENCES:

1. CDC - Guideline for Preven**ting Health Care Associated Pneumonia, 2003**~~ntion of Nosocomial Pneumonia~~

~~http://www.cdc.gov/ncidod/hip/pneumonia/pneu_mmw.htm~~**http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm**

2. CDC - Guideline for Environmental Infection Control in Healthcare Facilities ~~www.cdc.gov.env/hcw.htm~~**http://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf**

~~2.~~**3. ASHRAE 188: Legionellosis: Risk Management for Building Water Systems http://www.cdc.gov/legionella/health-depts/ashrae-faqs.html**

~~3. Minimizing the Risk of Legionellosis Associated with Building Water Systems: Maryland Dept of Public Health http://www.dhmh.state.md.us/html/legionella.htm~~

4. Legionnaires' **Disease Fact Sheet** ~~disease FAQ: http://www.hcinfo.com/ldfaq.htm~~**http://www.cdc.gov/legionella/downloads/fs-legionnaires.pdf**

~~5. Comparison chart of active potable water treatment methods by Johns Hopkins Hospital: http://www.hopkins-heic.org/infectious_diseases/water_table.htm~~

~~6.~~**5. Joint Commission Environment of Care Standard (EC.02.05.01)** ~~JCAHO Standard EC. 1.7 (formerly EC.1.9) http://www.jcaho.org/standards_frm.html\~~

6. OSHA Technical Manual, Section III: Chapter 7, Legionnaires Disease http://www.osha-slc.gov/dts/osta/otm/otm_iii/otm_iii_7.html

Environmental Risk Assessment

1) Municipal water is treated with chloramine. Data suggests that use of monochloramine is effective in eradicating Legionella. Monochloramines can reach distal points in a water system and can penetrate into bacterial biofilms more effectively than free chlorine.

EQUIPMENT	Location	Scale, Rust, or Biofilm Growth	Water Temp.	COMMENTS
Domestic Cold Water	Oceanside Main @ Thunder Dr. 10"	None	Ambient	Oceanside receives water from Municipal Water District of Southern California, all water treated with Chloramine Disinfectant @ 2.5 to 3.0 mg / l level. All backflow regulators are inspected and tested annually.
	Oceanside Main @ Vista Way, 10"	None	Ambient	Same as above.
	Vista Irrigation Main @ Thunder Dr., 8"	None	Ambient	Same as above.
	Hospital piping system.	None	Ambient	Entire domestic cold water system is run in copper and brass piping to prevent scale, rust or bio-film.
	(2) 10,000 gallon refill tanks on Pavilion roof top.	None, tanks are rubber lined.	Ambient	Tanks are opened and inspected annually. Tanks are not used for storage but replenished constantly. Water is supplied up to tanks and then pressure and gravity feed down to building.
Domestic Hot Water	Steam fed Heat Exchangers (6) throughout hospital	None	Monitored by computer to supply Title 22 required temperature water, 105 to 120 degrees F.	Domestic hot water piping is all run in copper and brass to prevent scale, rust or bio-film. All hot water systems are circulated constantly in order to provide constant temperature at sinks.
Reverse Osmosis and De-Ionized Water	Throughout facility, main system in penthouse of center tower, booster tanks located at Lab and 2 Pavilion.	None	Ambient	This system is highly filtered and treated water (Ultra Violet). System main function is for Dialysis and is routinely tested and monitored by our in-house laboratory.
Irrigation Water	Grounds	None	Ambient	Irrigation water is supplied from Vista Irrigation District (VID) who obtains their water from MWD, same as above.
Heating Hot Water	Throughout Facility, used for heating only, does not come in contact with patients.	None	Varies depending on outside air temperature, usually 140 degrees F. in winter, 120 degrees F. in summer.	Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system.

EQUIPMENT	Location	Scale, Rust, or Biofilm Growth	Water Temp.	COMMENTS
Chilled Water	Throughout Facility, used for cooling (air conditioning), does not come in contact with patients.	None	Varies depending on outside air temperature and demands of building, usually ranges between 42 to 55 degrees F.	Closed loop system, chemicals installed to stabilize water to prohibit corrosion of system.
Condenser Water Loop	Isolated to the Central Plant only. Cooling Tower is part of Air Conditioning System. Located 300 ft. away from main building.	Minor Bio-film, potential for rust and scale.	Temperature ranges between 78 to 95 degrees F. depending on outside air temperature and load on the system.	Requires most attention to ensure bio-film is kept to a minimum. Water is treated with sulfuric acid, bleach and biocides. A carefully designed and monitored program has been developed by Trident Technologies Water is tested daily by facilities staff to ensure we are within parameters.
Thermal Ice Storage Loop	Isolated to Central Plant only. Part of Air Conditioning system.	None	Temperature range is from 18 to 40 degrees F.	Glycol and water mix to specific gravity mix, closed loop system.
Steam Loop	Throughout, used for sterilization of instruments, heating hot water & domestic hot water through heat exchangers & humidification.	None	Average Temperature is 300 degrees F.	Basically a closed loop system except for discharge at sterilizers and humidifiers. Due to high temperature, not an issue.

Infection Control Risk Assessment

1) No cases of nosocomial Legionellosis have been identified at Tri-City Medical Center within the past ten years.
2) Legionnaires cultures are performed on bronchoscopy cultures and urinary Legionella antigen test is available in house.

High-Risk Patients	Unit	Prevention Strategies
Chemotherapy and Oncology	~~IMC~~**TELEMETRY**	Showers 1) The degree to which contaminated water is aerosolized into respirable droplets; 2) The proximity of the infectious aerosol to the potential host
COPD	Pulmonary Services	Sterile water used in nebulizers
End-stage renal disease	Dialysis	Filters are used in water lines in dialysis units, for the purpose of providing bacteria-free water for instrument reprocessing. Additionally, a reverse osmosis (RO) unit is usually added to the distribution system leading to PE areas.
Endoscopy	Surgery Services	Filters are used in water lines **for** the bronchoscope and endoscope washer/disinfectors.
Others	**ICU**~~ACCU~~, ~~IMC~~**TELEMETRY**, Med/Surg, Surgery, Pediatrics, Maternal/Child Services, NICU and ED	• Naso-gastric tubes are flushed with sterile water. • Reusable respiratory treatment devices that aerosolize fluids are rinsed with sterile water after use.

Comparison Chart of Water Disinfection Methods in a Hospital Environment

Item	Disinfection System							Combination Disinfection Systems	
	Super Heating & Flush	Auto - Chlorinating / Inhibitor System	Auto-Chloramine System (Mono-Chloramine)	Chlorine Dioxide	Copper-Silver Ionization System	Ozoniation	Ultraviolet	Ultraviolet & Auto-Chlorinating / Inhibitor System	Ultraviolet & Auto - Chloramine System (mono-chloramine)	Ultaviolet & Chlorine Dioxide
USED ON DOMESTIC COLD WATER SYSTEM	No	Yes	Yes	Yes	FEASIBLE - RETURN LOOP WITH FIXTURE / EQUIPMENT BACK FLOW PREVENTION REQUIRED	Yes	Yes	Yes	Yes	Yes
USED ON DOMESTIC HOT WATER SYSTEM	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CHEMICAL UTILIZED	None	SODIUM HYPOCHLORITE	CHLORAMINE (CHLORINE & AMMONIA)	CHLORINE DIOXIDE (SODIUM CHLORITE)	COPPER & SILVER (MINERALS)	NONE	NONE	SODIUM HYPOCHLORITE	CHLORAMINE (CHLORINE & AMMONIA)	CHLORINE DIOXIDE (SODIUM CHLORITE)
BY-PRODUCT	None	TRIHALOMETHANES (THM'S)	TRIHALOMETHANES (THM'S) (FAR LESS THAN CHLORINE)	SOME CHEMICAL DECOMPOSITION IN FORM OF CHLORITE AND CHLORATE	NONE	BROMATE	OZONE	TRIHALOMETHANES (THM'S)	TRIHALOMETHANES (THM'S) (FAR LESS THAN CHLORINE)	SOME CHEMICAL DECOMPOSITION IN FORM OF CHLORITE AND CHLORATE
EFFECTIVE MAX. pH	None	7.8 pH	9 pH	10 pH	8 pH	NA	NA	7.8 pH	9 pH	10 pH
TASTE & ODORS	None	YES - CAN CAUSE TASTE AND ODOR PROBLEMS	YES - CAN CAUSE TASTE AND ODOR PROBLEMS	NONE (BELOW .8 PPM) - REMOVES MOST TASTE AND ODORS PROBLEMS	NONE	YES - WILL ADD ODOR	NONE - PROVIDED HIGH INTENSITY OZONE LAMPS ARE NOT USED	YES - CAN CAUSE TASTE AND ODOR PROBLEMS / ONLY IF HIGH INTENSITY OZONE LAMPS ARE USED	YES - CAN CAUSE TASTE AND ODOR PROBLEMS / ONLY IF HIGH INTENSITY OZONE LAMPS ARE USED	NONE (BELOW .8 PPM) - REMOVES MOST TASTE AND ODORS PROBLEMS / ONLY IF HIGH INTENSITY OZONE LAMPS ARE USED
IMPACT ON EQUIPMENT AND SYSTEMS	Potential	POTENTIAL CORROSION PROBLEMS	MINIMAL POTENTIAL CORROSION PROBLEMS	MINIMAL POTENTIAL CORROSION PROBLEMS	MINIMAL POTENTIAL DEPOSITION OF COPPER ON MILD STEEL / LOCALIZED CORROSION - NONE REPORTED	POTENTIAL CORROSION PROBLEMS	POTENTIAL - CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE USED	POTENTIAL CORROSION PROBLEMS / ADDITIONAL CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE USED	MINIMAL POTENTIAL CORROSION PROBLEMS / ADDITIONAL CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE USED	MINIMAL POTENTIAL CORROSION PROBLEMS / ADDITIONAL CORROSION PROBLEMS IF HIGH INTENSITY OZONE LAMPS ARE USED

IMPACT ON DIALYSIS EQUIPMENT	None	NONE (BELOW 4 PPM) - CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE AND BY-PRODUCTS	SIGNIFICANTLY DIFFICULT TO REMOVE CHLORAMINES (MONO-CHLORAMINES) AND BY-PRODUCTS AT 4 PPM AND BELOW - CARBON FILTERS EFFECTIVE, RO MEMBRANE NOT EFFECTIVE, MEMBRANE DAMAGE	NONE (BELOW .8 PPM) - CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE DIOXIDE AND BY-PRODUCTS	INFORMATION CURRENTLY NOT AVAILABLE	INFORMATION CURRENTLY NOT AVAILABLE	NONE	NONE (BELOW 4 PPM) - CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE AND BY-PRODUCTS	SIGNIFICANTLY DIFFICULT TO REMOVE CHLORAMINES (MONO-CHLORAMINES) AND BY-PRODUCTS AT 4 PPM AND BELOW - CARBON FILTERS EFFECTIVE, RO MEMBRANE NOT EFFECTIVE, MEMBRANE DAMAGE	NONE (BELOW .8 PPM) - CARBON FILTERS AND RO EQUIPMENT EFFECTIVELY REMOVES CHLORINE DIOXIDE AND BY-PRODUCTS
ENVIRONMENTAL & HEALTH EFFECTS	WATER IS AT SCALDING TEMPERATURE	PRODUCES CARCINOGENIC THM'S.	PRODUCES CARCINOGENIC THM'S (less than chlorine).	NONE - DOES NOT PRODUCE THM'S AND CAN DESTROY SOME THM'S.	COPPER IS ACUTELY TOXIC TO MANY AQUATIC SPECIES AT LEVELS LOW AS 50 PPB. SYSTEM OPERATES BETWEEN 200 - 600 PPB COPPER, 10 TO 60 PPB SILVER.	NONE - BROMITE IDENTIFIED AS AN ANIMAL CARCINOGEN - EFFECTS ON HUMANS UNKNOWN	NONE	PRODUCES CARCINOGENIC THM'S.	PRODUCES CARCINOGENIC THM'S (less than chlorine).	NONE - DOES NOT PRODUCE THM'S AND CAN DESTROY SOME THM'S.
EPA APPROVED PRIMARY DRINKING WATER DISINFECTANT	No	YES (below 4 ppm)	YES (below 4 ppm)	YES (below .8 ppm)	NO	NO	NO	YES (below 4 ppm)	YES (below 4 ppm)	YES (below .8 ppm)
BREAKS DOWN BIOFILM (AT NOMINAL OPERATING CONDITIONS)	Yes	NO @ BELOW 50 PPM - MINIMAL ABOVE 50 PPM (SYSTEM OPERATES BETWEEN 2 - 3 PPM)	NO - (SYSTEM OPERATES AT 2-3 PPM)	YES	YES / NO - DEPENDING ON PPM	NO	NO	NO @ BELOW 50 PPM - MINIMAL ABOVE 50 PPM (SYSTEM OPERATES BETWEEN 2 - 3 PPM)	NO - (SYSTEM OPERATES AT 2-3 PPM)	YES
INHIBITS BIOFILM (AT NOMINAL OPERATING CONDITIONS)	No	MINIMAL	MINIMAL	YES	YES / NO - DEPENDING ON PPM	NO	NO	MINIMAL	MINIMAL	YES
SHORT TERM RESIDUAL EFFECTIVENESS AGAINST LEGIONELLA (SYSTEM NOT OPERATING)	YES - (APPROX. ONE WEEK)	YES	YES - FAR LESS EFFECTIVE AS CHLORINE	YES	YES	NO	NO	YES	YES - (FAR LESS EFFECTIVE AS CHLORINE)	YES

.ONG TERM :ESIDUAL :FFECTIVENESS \GAINST .EGIONELLA SYSTEM NOT)PERATING)	None	NONE	NONE	MINIMAL - SOME RESIDUAL PROTECTION UNTIL BIOFILM IS RE-ESTABLISHED - NONE FOR BULK WATER	YES FOR HOT WATER SYSTEMS ONLY - (LONG TERM STUDIES [4 YEARS] INDICATE LEGIONELLA MAY DEVELOP A TOLERANCE TO SILVER)	NONE	NONE	NONE	NONE	MINIMAL - SOME RESIDUAL PROTECTION UNTIL BIOFILM IS RE-ESTABLISHED NONE FOR BULK WATER
'LUSHING :EQUIRED AT \LL FIXTURES \T START UP \ND ON 'ERIODIC BASES	Yes	YES	YES	YES	YES	YES	YES	YES	YES	YES
:HLORINE ;HOCKING OF VATER SYSTEM :EQUIRED 'RIOR TO ;YSTEM)PERATING SHOCKING :FFECTS BULK VATER ONLY - IO EFFECT ON ;IOFILM)	NA	YES	YES	NOT REQUIRED	NOT REQUIRED	YES	YES	YES	YES	NOT REQUIRED
:STIMATED FOR \ 600 GPM ;YSTEM (NOT \NSTALLED)	NA	$9,000 (approx.)	$9,000 (approx.)	$12,000	$36,000	NOT AVAILABLE	$27,000	$36,000 (approx.)	$42,000 (approx.)	$39,000
:STIMATED \NSTALLATION :OST	NA	$5,000 (approx.)	$5,000 (approx.)	$3,000	$5,000	NOT AVAILABLE	$10,000	$15,000 (approx.)	$15,000 (approx.)	$13,000
:STIMATED \NNUAL /AINTENANCE :OST	$12,500 (PER EVENT)	$8,000	$8,000	$16,650 @ 1 LB ClO2 OR $28,250 @ 2 LBS ClO2	$25,250	NOT AVAILABLE	$12,600	$20,600	$20,600	$20,000 @ 1 LB ClO2 OR $32,000 @ 2 LBS ClO2

Prepared by Gregory Bova - JHH Facilities Engineering *(Last updated January 30, 2001)*

Fact Sheet for Legionellae

Infection and Disease

Legionellae are bacteria. When legionellae are present in aquatic environments, the risk of catching an infection depends on several factors: conditions favorable for growth of the organism, a way of releasing the bacteria (e.g., aerosolization of colonized water), the organism reaches a site where it is capable of causing infection, which specific strains of bacteria are involved, and the susceptibility of the host. Over 40 species of *Legionella* have been identified; *L. pneumophlla* appears to be the easiest to catch and causes approximately 90% of cases of Legionellosis. Older persons and those who smoke tobacco or have chronic lung disease are more likely to become infected. Persons whose immune system is decreased (certain drugs or underlying medical conditions) are at particularly high risk.

Habitats

Legionellae bacteria are commonly present in natural and man-made water environments. The organism is occasionally found in other sources, such as mud from streams and potting soils. In natural water sources and municipal water systems, legionellae are generally present in very low or undetectable concentrations. However, under certain circumstances within manmade water systems, the concentration of organisms may increase markedly, a process termed "amplification." Conditions that are favorable for this amplification include water temperatures of 25-42^{0}C (77-108^{0}F), stagnation, scale and sediment, biofilms, and the presence of amoebae.

Legionellae infect and multiply within several species of free-living amoebae, as well as ciliated protozoa. The initial site of infection in humans with Legionnaires' disease is the pulmonary macrophage. These cells engulf legionellae and provide an environment that is remarkably similar to water protozoa. Within these cells the bacteria can grow and multiply. Hence, legionellae may be considered protozonotic; i.e., they naturally infect free-living amoebae and incidentally infect the phagocytic cells within human lungs under certain circumstances.

There is an indication that certain materials influence growth of Legionella. Natural rubbers, wood, and some plastics have been shown to support the amplification of *Legionella,* while other materials such as copper inhibit their growth. Generally, *Legionella* thrive in diverse, complex microbial communities because they require nutrients and protection from the environment. Controlling the populations of protozoa and other microorganisms may be the best means of minimizing *Legionella.*[2]

Transmission of Legionnaires' Disease

Investigations of outbreaks of Legionnaires' disease supply most of the information we have about how the disease is passed to humans. These studies suggest that, in most instances, transmission to humans occurs when water containing the organism is aerosolized in respirable droplets (1-5 micrometers in diameter) and inhaled by a susceptible host. A variety of aerosol-producing devices have been associated with outbreaks of Legionnaires' disease, including cooling towers, evaporative condensers, showers, whirlpool spas, humidifiers, decorative fountains, and a grocery store produce mister. Aspiration of colonized drinking water into the lungs has been suggested as the mode of transmission in some cases of hospital-acquired Legionnaires' disease.

The most effective control for most diseases, including Legionellosis, is prevention of transmission at as many points as possible in the disease's chain of transmission. If one preventive measure fails, others will be in place and act as fail-safe mechanisms. With this philosophy in mind, it may be desirable to design measures to prevent transmission of Legionellosis at as many points as possible in the disease's chain of transmission. The ~~Prevention of~~ Waterborne Illness policy outlines the **preventative** steps Tri-City Medical Center has taken to break this chain of transmission.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL MANUAL

SUBJECT: Zika Virus

ISSUE DATE: NEW
REVISION DATE(S):

Infection Control Department Approval:	**10/16**
Infection Control Committee Approval:	**10/16**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **DEFINITION:**
1. Zika virus is a member of the virus family Flaviviridae and the genus Flavivirus. It is spread by daytime-active Aedes mosquitoes, such as A. aegypti and A. albopictus. Its name comes from the Zika Forest of Uganda, where the virus was first isolated in 1947. Zika virus is related to the dengue, yellow fever, Japanese encephalitis, and West Nile viruses. Since the 1950s, it has been known to occur within a narrow equatorial belt from Africa to Asia. From 2007 to 2016, the virus spread eastward, across the Pacific Ocean to the Americas and the Caribbean leading to the 2015–16 Zika virus epidemic.

B. **TRANSMISSION**:
1. Zika virus is primarily transmitted to humans through the bite of an infected Aedes species mosquito (Ae. aegypti and Ae. albopictus). In addition, Zika virus can be transmitted from a pregnant women to her fetus, and through sex. It is very likely that Zika can be transmitted through blood transfusion. The Zika virus remains in a person's blood an average of 7 days after being infected. Zika virus is not transmitted through the air or directly from one person to another through casual contact.

C. **SYMPTOMS:**
1. Many people infected with Zika virus won't have symptoms or will only have mild symptoms. People usually don't get sick enough to go to the hospital, and they very rarely die of Zika. Symptoms of Zika are similar to other illnesses spread through mosquito bites, like dengue, yellow fever, chikungunya, and West Nile. There is an association between Zika and Guillain-Barre syndrome, a disease affecting the nervous system.
   a. The most common symptoms are: fever, rash, joint pain, conjunctivitis (red eyes). Others include muscle pain & headache. Symptoms can last for several days to a week.
   b. Zika during pregnancy can cause birth defects of the fetal brain called microcephaly (small head and brain) and other brain defects. Other problems have been detected among fetuses and infants infected with Zika virus before birth, such as defects of the eye, hearing defects, impaired growth and developmental delays.

D. **PRECAUTIONS:**
1. All healthcare personnel when providing any care to a suspected or confirmed Zika patient should follow Standard Precautions per Infection Control (IC) Policies: Standard and Transmission Based Precautions and Bloodborne Pathogens Exposure Control Plan.
   a. Standard precautions include, but are not limited to:
      i. Hand hygiene

ii. Gloves
iii. Gown
iv. Mask and eye protection to avoid direct contact with blood and other potentially infectious material, including laboratory specimens.

E. **DIAGNOSIS & TESTING:**

1. Diagnosis of Zika is based on a person's recent travel history, symptoms, and test results. Testing will be performed based on Centers for Disease Control and Prevention (CDC) current recommendations.
2. Healthcare providers wishing to have a patient tested for Zika virus MUST contact the local San Diego County Public Health Epidemiology department for consultation and approval at (619)-692-8499.
   a. For after hours, weekends or holidays call 858-565-5255 and ask for the Epidemiology Duty Officer.
3. The healthcare provider will be directed by the Epidemiologist to fill out a CDPH-Viral and Rickettsial Disease Lab Specimen Submittal form which is required when testing is requested:
   a. **http://www.cdph.ca.gov/programs/vrdl/Documents/VRDL_General_Human_Specimen_Submittal_Form_Lab300.pdf.**
4. The healthcare provider must submit a copy of this form to the Laboratory in order for a specimen to be ordered and processed. Contact the Laboratory to obtain specimen at ext 7906 or 7907.
5. Staff should contact Infection Prevention & Control at extension 7410 or 5696 with any suspect cases.

F. **OCCUPATIONAL EXPOSURE:**

1. Immediately report the exposure to staff Supervisor, Charge Nurse or Manager as per Employee Health & Wellness policy: Guidelines for Reporting Exposure.
2. Employee Health Services will institute appropriate follow up.

G. **FORMS:**

1. General Purpose Specimen Submittal Form Sample

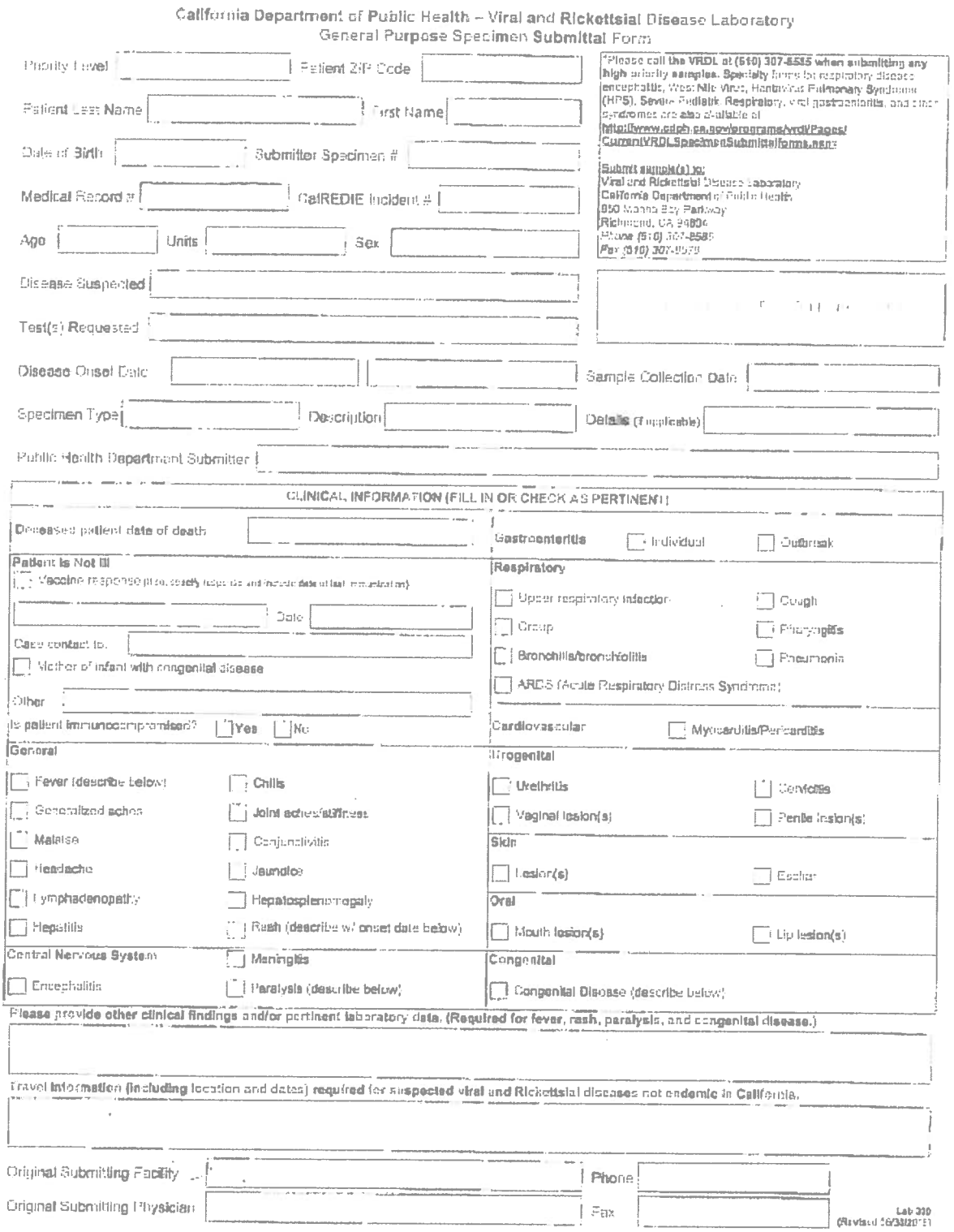
H. **RELATED DOCUMENT(S):**

1. IC Policy: Standard and Transmission Based Precautions
2. IC Policy: Bloodborne Pathogen Exposure Control Plan
3. Employee Health and Wellness Policy Manual: Guidelines for Reporting Exposures Policy

I. **REFERENCE LIST & EXTERNAL LINK(S):**

1. http://www.cdc.gov/zika/about/overview.html
2. http://www.cdc.gov/zika/pdfs/key-zika-considerations.pdf
3. http://www.cdph.ca.gov/HealthInfo/discond/Documents/ZIKAVirusFAQsforHealthCareProviders.pdf
4. http://www.cdph.ca.gov/programs/vrdl/Documents/Zika_Testing_VRDL_Quicksheet.pdf
5. http://www.cdc.gov/zika/pdfs/when-to-test-zika.pdf
6. https://www.osha.gov/Publications/OSHA3855.pdf
7. http://www.cdc.gov/zika/pdfs/testing_algorithm.pdf

General Purpose Specimen Submittal Form Sample



California Department of Public Health – Viral and Rickettsial Disease Laboratory
General Purpose Specimen Submittal Form

Priority Level | Patient ZIP Code

Patient Last Name | First Name

Date of Birth | Submitter Specimen #

Medical Record # | CalREDIE Incident #

Age | Units | Sex

Disease Suspected

Test(s) Requested

Disease Onset Date | Sample Collection Date

Specimen Type | Description | Details (if applicable)

Public Health Department Submitter

*Please call the VRDL at (510) 307-8585 when submitting any high priority samples. Specialty tests for respiratory disease encephalitis, West Nile Virus, Hantavirus Pulmonary Syndrome (HPS), Severe Pediatric Respiratory, viral gastroenteritis, and other syndromes are also available at http://www.cdph.ca.gov/programs/vrdl/Pages/CurrentVRDLSpecimenSubmittalforms.aspx

Submit sample(s) to:
Viral and Rickettsial Disease Laboratory
California Department of Public Health
850 Marina Bay Parkway
Richmond, CA 94804
Phone (510) 307-8585
Fax (510) 307-8570

CLINICAL INFORMATION (FILL IN OR CHECK AS PERTINENT)

Deceased patient date of death

Patient is Not Ill
- Vaccine response (list vaccine(s) received and include date of last immunization)
- Date
- Case contact to:
- Mother of infant with congenital disease
- Other

Is patient immunocompromised? Yes No

General
- Fever (describe below)
- Chills
- Generalized aches
- Joint aches/stiffness
- Malaise
- Conjunctivitis
- Headache
- Jaundice
- Lymphadenopathy
- Hepatosplenomegaly
- Hepatitis
- Rash (describe w/ onset date below)

Central Nervous System
- Meningitis
- Encephalitis
- Paralysis (describe below)

Gastroenteritis: Individual, Outbreak

Respiratory
- Upper respiratory infection
- Cough
- Croup
- Pharyngitis
- Bronchitis/bronchiolitis
- Pneumonia
- ARDS (Acute Respiratory Distress Syndrome)

Cardiovascular: Myocarditis/Pericarditis

Urogenital
- Urethritis
- Cervicitis
- Vaginal lesion(s)
- Penile lesion(s)

Skin
- Lesion(s)
- Eschar

Oral
- Mouth lesion(s)
- Lip lesion(s)

Congenital
- Congenital Disease (describe below)

Please provide other clinical findings and/or pertinent laboratory data. (Required for fever, rash, paralysis, and congenital disease.)

Travel information (including location and dates) required for suspected viral and Rickettsial diseases not endemic in California.

Original Submitting Facility | Phone

Original Submitting Physician | Fax

Lab 310
(Revised 10/30/2015)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY MANUAL

ISSUE DATE: 4/09	**SUBJECT:** Disaster Privileges
REVISION DATE: 9/09	**POLICY NUMBER:** 8710-553

Medical Staff Department Approval:	08/16
Credentials Committee Approval:	08/16
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	11/16
Professional Affairs Committee Approval:	01/17
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide a process to credential and grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or Allied Health Professionals (AHP's), as appropriate, in the event of a disaster when the HICS plan has been activated and the hospital is unable to meet immediate patient care needs.

~~1.~~2. SCOPE and RESPONSIBIITY includes the Medical Staff Services Department of Tri-City Medical Center or Designee and the designated Disaster Coordinator.

~~2. To identify criteria for granting disaster privileges to non-members of Tri-City Medical Staff when the TCMC Emergency Management Plan has been activated and/or the immediate needs of the organization are unable to meet immediate patient needs.~~

B. **DEFINITIONS AND TERMS:**

~~1. Disaster Privileges: Disaster Privileges are time-limited privileges, which may be granted to physicians and allied health professionals (AHP) when the emergency management plan has been activated and the organization is in need of additional resources and appropriate expertise to handle the immediate patient needs during a disaster. The Chief Executive Officer (CEO), chief of staff, or designee may grant such privileges (also refer to Medical Staff Policy #4045: Emergency Preparedness Management).~~

1. The following definitions shall apply for purposes of this policy and procedure only.
   a. Practitioner: A physician (M.D., D.O.), podiatrist (D.P.M.), dentist or oral maxillofacial surgeon (D.D.S., D.M.D.)
   b. Allied Health Professional or AHP: All health care professionals other than Practitioners, as defined above, who are classified as Dependent practitioners to work as a physician extender under the direction of a supervising physician and required by law and regulation to have a license, certificate or registration to practice their profession and.
   c. Surgical Tech, Orthopedic Tech shall be credentialed as follows:
      i. If a "tech" is employed by another hospital, they will be sent to Human Resources for appropriate credentialing.
      ii. Any "tech" who is not employed by another hospital will be credentialed per this policy.
   d. Volunteer Practitioner or AHP: A Volunteer Practitioner who is not currently a member of the medical staff of Tri-City Medical Center, or an AHP who has not been credentialed as an AHP by the facility.
   e. Disaster Clinical Privileges: Clinical Privileges granted to a Volunteer Practitioner, as defined above, pursuant to this policy and procedure.
   ~~a.~~f. Disaster Practice Prerogatives: Practice prerogatives granted to an AHP, as

defined above, pursuant to this policy and procedure.

~~C. POLICY:~~

~~1. In the case of a disaster in which the disaster plan has been activated and the hospital is unable to handle the immediate patient needs, the Chief of Staff, or in the absence of Chief of Staff, the Vice-Chief of Staff, may grant disaster privileges.~~

~~a. In the absence of the Chief of Staff and Vice-Chief of Staff and Department Chair(s), the CEO or designee may grant the disaster privileges consistent with this policy.~~

~~b. The grant of privileges shall be on a case-by-case basis at the sole discretion of the individual authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges shall be continued.~~

~~2. The verification process of the credentials and privileges of individuals who receive disaster privileges, shall be developed in advance of a disaster situation. This process shall begin as soon as the immediate disaster situation is under control, and shall meet the following requirements in order to fulfill important patient care needs:~~

~~a. Identifies in writing the individual(s) responsible for granting disaster privileges.~~

~~b. Describes in writing the responsibilities of the individual(s) responsible for granting disaster privileges.~~

~~c. Describes in writing a mechanism to manage the activities of individuals who receive disaster privileges. There is a mechanism to allow staff to readily identify these individuals.~~

~~d. Addresses the verification process as a high priority.~~

~~e. Ensures the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control.~~

~~3. The process for disaster privileges is identical to the process established under the medical staff bylaws for granting temporary privileges to fulfill an important patient care need.~~

~~4. Members of the medical staff shall oversee those granted disaster privileges.~~

~~D.~~C. PROCEDURE:

1. Upon presentation to the hospital, Volunteer Practitioners and/or AHPs shall be directed to the Hospital Representative responsible for disaster credentialing under the HICS plan.
   a. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows:
      i. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:
         1) A current hospital photo ID badge that clearly identifies professional designation;
         2) A current license, certificate or registration to practice, as appropriate;
         3) Identification indicating the individual is a member of a Disaster Medical Assistance Team (*DMAT*), or Medical Reserve Corps (*MRC*), Emergency System for Advanced Registration of Volunteer Health Professionals (*ESAR-VHP*), or other recognized state or federal organizations or groups;
         4) Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a deferral state, or municipal entity); or
         5) Identification of Volunteer Practitioners by current hospital or medical staff members(s) who possess personal knowledge regarding the Volunteer Practitioner's ability to act as a licensed independent practitioner during a disaster and of Volunteer AHPs by current hospital member(s) who possess personal knowledge

regarding the AHP's qualifications.

b. Required Documentation on the Disaster Privileges/Prerogative Approval Form:
   i. Name of Volunteer Practitioner or AHP (printed and signed)
   ii. Specialty or AHP Category
   iii. Office Address and Phone Number
   iv. Professional License/Certificate/Registration Number and Expiration Date
   v. Driver's License or Passport Number and Expiration Date
   vi. Date of Birth
   vii. Name of Professional Liability Insurance Carrier and Limits of Liability
   viii. Name of Professional School and Year of Graduation
   ix. Hospital Affiliation(s) and Staff Status

c. Verification Process:
   i. The hospital Representative shall verify professional licenses/certificates/ registrations as follows:
      1) Primary Source Verification:
         a) Query the appropriate licensing/certification/registration board on-line, e.g.= Medical Board of California website = *www.medbd.ca.gov* – use for M.D.s, D.P.Ms and PAs; California Osteopathic Medical Board = *www.ombc.ca.gov* – use for D.O.s, California Board of Registered Nursing = www.rn.ca.gov – use for R.N.F.A.s, N.P.s, C.N.M.s and other R.N.s; Board of Behavioral Sciences = www.bbs.ca.gov --- use for M.F.C.C.s and L.C.S.W.s; California Psychology Board = www.psychboard.ca.gov –use for clinical psychologists, and print verification if possible.
      2) If computer access is not available, a copy (if possible) of the Volunteer Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification shall be made and attached to the Disaster Privilege/Prerogative Approval Form. If a copier is not available, the Hospital Representative shall perform a visual verification of the above documents, and document such verification.
      3) If primary source verification of professional licensure/certification/ registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control and completed no later than seventy-two (72) hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours (e.g., no means of communication or lack of resources) it shall be accomplished as soon as possible. In this extraordinary circumstance, the following must be documented:
         a) Why primary source verification could not be performed in the required timeframe;
         b) Evidence of the Volunteer Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
         c) Attempt(s) to rectify the situation as soon as possible.
      4) The Medical Staff Services Representative or designee shall query the National Practitioner Data Bank (NPDB) and other sources as needed as soon as the emergency situation has been contained.
      5) Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment and services under the Disaster Clinical Privileges or Practice Prerogatives, as

appropriate.

d. Who May Grant Disaster Clinical Privileges/Practice Prerogatives:
   i. As described in the Medical Staff Bylaws, the Chief Executive Officer (CEO) or Chief of Staff or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the hospital's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.

e. Temporary Badges:
   i. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:
      1) Name
      2) Specialty or AHP category
      3) Practicing with Disaster Clinical Privileges or Practice Prerogatives, as appropriate.

f. Oversight:
   i. The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges or Practice Prerogatives. Oversight shall be accomplished whenever possible by partnering the Volunteer Practitioner or AHP with a current credentialed medical staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP. If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Staff Officer designated under the *HICS* plan.

g. Termination of Disaster Clinical Privileges/Practice Prerogatives:
   i. A Volunteer Practitioner's or AHP's Disaster Clinical Privileges or Practice Prerogatives shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Volunteer prac
   ii.
   iii. Volunteer Practitioner or AHP is not capable of exercising Disaster Clinical Privileges or Practice Prerogatives. Disaster Clinical Privileges and Practice Prerogatives are time-limited and shall expire automatically at the time the CEO or designee declares the disaster to be over, or that the services of Volunteer practitioners or AHPs are no longer required.

~~E. PROCEDURE:~~

~~1. Disaster privileges may be granted to volunteers eligible to be Licensed Independent Practitioners and Allied Health Professionals upon presentation of a valid picture identification issued by the state, federal, or regulatory agency and at least one of the following:~~

~~a. A current picture hospital identification card clearly identifying professional designation.~~

~~b. A current license to practice.~~

~~c. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.~~

~~d. Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.~~

~~e. Identification by current hospital or medical staff member(s) with personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.~~

~~2. Disaster Response:~~

~~a. All non-Medical Staff who are granted disaster privileges will respond to the Physician Labor Pool in Physicians Dining Room and appropriate name badge provided~~

~~(appropriate name badge is defined by Medical Staff Policy #8710-521, *Name Tags for Health Practitioners*).~~

~~3. Pending Verifications Process:~~

~~a. Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours.~~

~~i. If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:~~

~~1) The reason(s) verification could not be performed within 72 hours of the practitioner's arrival.~~

~~2) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.~~

~~3) Evidence of an attempt to perform primary source verification as soon as possible.~~

~~4. Oversight of Volunteer Practitioner:~~

~~a. The Medical Director or designee will provide oversight of the care, treatment and services provided by the volunteer practitioner, by either direct observation, mentoring or chart review and will determine whether the volunteer practitioner's disaster privileges will be continued for the duration of the disaster situation. Within 72 hours, the organization will make a decision on information that is obtained from the Medical Director or designee to continue the volunteer practitioner's practice.~~

~~i. When the disaster situation no longer exists, these disaster privileges terminate.~~

~~E.~~**D. REFERENCES**:

1. The Joint Commission Standards

~~1. Inside the Joint Commission, Vol. 13 No. 4, March 3, 2008.~~

~~2. The Joint Commission Standards EM.02.02.13 and EM.02.02.15~~

APPLICATION FOR DISASTER PRIVILEGES

To be completed by the Volunteer Licensed Independent Practitioner/Volunteer Practitioner

Full Name:_____
Cell Phone Number:_____
Social Security Number:_____
Date of Birth:_____
Office Address, City, State, Zip Code:_____
_____
Office Telephone:_____
Photo Identification Type (i.e., driver's license, government I.D.)
_____
Identifying Number:_____
Issuing State/Agency:_____
(If copy not obtained, list other information):_____
_____
License (certification or registration) Number:_____
Issuing State:_____
Expiration Date:_____
(If copy not obtained, list issuing agency name/address/phone/other information)
_____
Malpractice Insurance Carrier Name:_____
Telephone Number (if available):_____

Current Hospital Affiliation(s) – Facility(s) Name(s)
Address(s), City(s), State(s), Zip Code(s)
Telephone Number(s)
_____
_____
_____

LIP/Volunteer Practitioner's Signature:_____

VERIFICATIONS/APPROVAL

Review all documents and attach copies if possible. Conduct verification of information as possible

License/Certification/Registration:_____ Affiliation(s):_____

Insurance:_____ NPDB:_____OIG:_____Other:_____

On Site Medical Staff Member's Name:_____

Responsibilities (following interview with volunteer Health Care Practitioner):_____

_____

_____

Assigned Partner:_____

Approved by: (print name, signature, title):_____

CONSENT, ACKNOWLEDGEMENT & RELEASE OF INFORMATION FOR DISASTER PRIVILEGES

I, the undersigned, hereby apply for disaster privileges as requested on this application. I acknowledge and agree to abide by the Medical Staff Bylaws, Rules and Regulations and applicable hospital policies. By applying for disaster privileges, I accept the following conditions during the processing and consideration of my application and for the duration of my privileges, regardless of whether or not I am granted the privilege requested:

1. I agree the information provided in conjunction with this application is accurate and represents the current level of my training, experience, capability, health status and competence to practice the disaster privileges requested.

2. I fully understand and agree that any significant misrepresentation, misstatement or omission from this application, whether intentional or not, shall constitute cause for denial of requested disaster privileges. In the event that disaster privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary termination of disaster privileges.

3. I hereby authorize my professional liability insurance carrier to notify the Chief of Staff or his agent, in the event that my insurance coverage is terminated, canceled, modified or otherwise acted upon.

4. I understand and agree that as an applicant for disaster privileges that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, health status, and other qualifications and for resolving any doubts about such qualifications. I agree to make myself available for interviews with regard to my application and any peer review related matters during the time that I hold disaster privileges.

5. I agree to provide continuous care for my patients either personally or through an identified qualified member of the medical staff.

6. Immunity is extended to the fullest extent permitted by law and I release from liability all persons, organizations, committees and their agents from participating in good faith in requesting or supplying information relative, but not limited to: (a) applications for appointment and/or clinical privileges; (b) periodic reappraisals undertaken as part of the peer review process; (c) investigations, reprimands, corrective action, suspension or reduction of clinical privileges, or other disciplinary action; (d) hearings and appellate reviews: (e) reviews before the governing board; (f) case evaluations; (g) utilization reviews: (h) other hospital, medical staff or departmental, service or committees activities relating to the quality of patient care or my professional conduct; (i) inquiries concerning my professional qualifications, character, ethics, physical or mental health status, or behavior; and (j) any other matter that may affect patient care, or the orderly operation of this or any other hospital, and I hereby authorize and consent to the release of such information.

7. I understand and agree that after I submit this application it is my sole obligation to promptly report to the Chief of Staff or his designee of any: (1) change in the contents of this application; (2) change in my physical or mental health that could impair my ability to practice; (3) change in my staff membership or privileges at any other health care facility; (4) investigation or accusation with regard to my license or DEA; or (5) conviction of, or plea of guilty or no contest, or its equivalent, to a felony in any jurisdiction; (6) sanction and/or exclusion from participation in any Federal health care program; or (7) change in the status of my professional liability insurance coverage.

8. I present this application and arrange for the submission of other information with the understanding: (1) that such information is requested by the peer review committee(s) of this hospital as part of the credentialing process; (2) that the confidentiality and privacy of this information will be preserved; and (3) that this information and materials will only be released or disclosed as part of current or future credentialing, peer review or quality improvement processes as described above and in the medical staff bylaws, rules and regulations.

9. I understand that the completion of this application is my sole responsibility. I declare that the information on this application is true and without omission to the best of my knowledge. I hereby apply for disaster privileges.

SIGNATURE: _____ DATE: _____

SUBJECT: AMPHOTERICIN-B LIPOSOME (AMBISOME), ORDERING AND INFUSION OF

ISSUE DATE: 6/07
REVISION DATE: 06/09, 6/11, 8/12

Department Approval:	**11/15**
Perinatal Collaborative Practice Approval:	**08/16**
Division of Neonatology Approval:	**08/16**
Pharmacy and Therapeutics Approval:	**11/16**
Medical Executive Committee Approval:	**11/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To prevent the incidence of hypoglycemia and/or hyperglycemia in the VLBW infant, during infusion of the Amphotericin-B Liposomal (AmBisome), the following guidelines are recommended.

B. **POLICY:**

1. All orders for Amphotericin-B in the NICU will be for Amphotericin-B Liposomal (AmBisome).
2. When using a double lumen central line (PICC or UVC):
   a. The pharmacist will prepare the ordered dose of Amphotericin-B Liposomal in D_5W.
   b. The Amphotericin B Liposomal will be infused through the secondary port. If there are IV fluids, including TPN, infusing in the secondary port, per physician orders, the hourly infusion volume will be changed on the primary port to be inclusive of both ports total hourly volume.
   c. Primary IVFs will continue to be infused through the primary port of the central line. There is no need to stop the IVFs including TPN during infusion of the Amphotericin-B Liposomal.
3. When using single lumen central line (PICC or UVC) or PIV:
   a. When Amphotericin-B Liposomal is ordered and a baby is receiving TPN/Lipid or IV therapy greater than 5% dextrose through a single lumen central line or PIV, the medication will be prepared as follows:
      i. The pharmacist will calculate the amount of dextrose (in grams) that the neonate receives in a two-hour period (timeframe for Amphotericin-B Liposomal infusion).
      ii. The pharmacist will calculate the amount of dextrose concentration necessary for the Amphotericin-B Liposomal to deliver the same or slightly greater amount of dextrose over two hours.
      iii. Amphotericin-B Liposomal will be prepared in a standard concentration of 0.5 – 2 mg/ml and added to the dextrose solution concentration calculated in (b) above.
      iv. The rate of administration of the Amphotericin-B Liposomal admixture will be such that the entire infusion will be completed in two hours.
      v. TPN/Lipids will be stopped during the infusion of Amphotericin-B Liposomal, which will be infused through the same IV access site.
4. For all Amphotericin-B Liposomal Infusions:
   a. Due to incompatibility of normal saline with Amphotericin-B Liposomal, D_5W will be used to clear the line both prior to, and after the infusion.
   b. During the infusion of Amphotericin-B, Liposomal blood glucose will be monitored one hour after the start of the infusion and again one hour after completion of the infusion.

c. Infants will remain on strict I&O for the duration of treatment course.

A. **EXTERNAL LINKS:**

C. **REFERENCES:**

1. Wilson, S. S. (2005). Nurses's Drug Guide. Prentice Hall.
2. Young, T.E. & Magnum, B. (2011). Neofax, 24th Ed., Raleigh, NC.
3. Zenk, K.E., Sills, J.H., & Koeppel, R.M. (2003). Neonatal Medications and Nutrition, 3rd Edition.

Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. *Neonatology: management, procedures, on-call problems, diseases, and drugs.* 7th. New York: McGraw Hill Education Lange, 2013.

McMillan, Julia A., and Carlton K.K. Lee, et.al. *The Harriet Lane Handbook of Pediatric Antimicrobial Therapy.* 2nd. Philadelphia: Elsevier Saunders. 2014.

Neofax, 24th Ed., Raleigh, NC: Thomson Reuters. 2011.

B. **APPROVAL PROCESS**

1. **Clinical Policies & Procedures Committee**
2. **Nurse Executive Council**
3. **Medical Executive Committee**
4. **Professional Affairs Committee**

Board of Directors

Tri-City Medical Center
Oceanside, California

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: CONSULTATION TO PERNINATAL UNIT

ISSUE DATE: NEW
REVISION DATE(S):

Department Approval:	**11/16**
Perinatal Collaborative Practice Approval:	**11/16**
Division of Neonatology Approval Date:	**11/16**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**11/16**
Professional Affairs Committee Approval:	**01/17**
Board of Directors Approval:	

A. **DEFINITION(S):**

1. Perinatal Unit: A perinatal unit means a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space, equipment and supplies.

B. **POLICY:**

1. A neonatologist or Allied Health Professional (AHP) shall be available for perinatal unit consults as requested by an OBGYN or Certified Nurse Midwife.

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**EPIDURAL /PATIENT CONTROLLED EPIDURAL ANESTHESIA (PCEA) AND SPINAL BLOCK MANAGEMENT**
Purpose:	To provide the nursing management **for** ~~of the adolescent adult~~ patient receiving epidural analgesia, continuous PCEA ~~(Patient controlled Epidural Analgesia)~~ **and** SAB (Spinal Anesthesia Block)~~. or CSE (Continuous Spinal Epidural).~~
~~Supportive Data:~~	
Equipment:	1. Electronic Fetal Monitor 2. Intravenous(IV) Administration Set 3. IV Fluids as ordered by provider 4. Epidural Infusion Pump and Key 5. Epidural Insertion Kit 6. Medications as ordered by Anesthesiologist 7. Blood Pressure Monitor 8. Pulse Oximeter 9. Oxygen delivery and suctioning equipment
~~Issue Date:~~	~~5/94~~

A. **POLICY:**

1. The Anesthesiologist and ~~the assigned~~ **Labor &Delivery (L&D) nurse** ~~RN~~ share the responsibility for the observation and monitoring of the patient and/or her unborn fetus receiving epidural /spinal anesthesia.
2. Patients receiving PCEA anesthesia must have a dedicated syringe pump infusion channel that is positioned on the opposite side of the mainline intravenous channels, which can be locked and has set guardrails.
3. **The Anesthesiologist shall ~~will~~ obtain informed consent** from the patient **and be responsible for:**
   - a. ~~place the e~~**Epidural catheter or spinal anesthesia ~~algesia~~ placement**
   - b. **Entering orders for epidural management** to ensure rates for administration are clear for infusion pump programming.
   - c. Using **the epidural/ PCEA specific tubing (containing a yellow stripe)** which indicates it **is an epidural line and NOT to be used for any other reason.**
   - ~~2.~~**d. Administering all bolus doses and changing rates on the infusion pump**
     - i. Any increase or decrease in the rate of continuous PCEA must be ~~done~~**ordered** by the Anesthesiologist **and may be performed by the nurse with a second nurse to witness the adjustment**.
     - ii. **After two ordered dose changes if the patient continues to have pain at the same or increased intensity the patient shall be evaluated by the anesthesiologist.**
   - e. **Connecting** the medication syringe **tubing to the epidural catheter**
   - f. **Ensuring documentation requirements on anesthesia record are complete according to department standards**
4. **Prior to insertion, the nurse will** ensure anesthesia consent is signed.
5. The pharmacy department is responsible for the preparation of the epidural **continuous infusion medication syringe.** ~~/ spinal anesthesia.~~

~~3.~~**6. The patient is the ONLY person who is authorized to use the dose request cord/button to administer medication on demand.**

a. **PCEA by PROXY is PROHIBITED and this must be reviewed with the patient and family by the Anesthesiologist and nurse.**

Department Review	Department of OB/GYN	Division of Neonatology	Department of Pediatrics	Department of Anesthesia	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
4/95, 10/96, 5/97, 11/97, 3/00, 11/02, 11/03, 12/08, 7/09, 6/13, 12/14	01/13	n/a	n/a	10/16	11/16	05/13, 11/16	06/13, 01/17	7/09, 6/13

B. **PRE-PROCEDURE:**

1. The nurse will confirm Obstetrician's order for regional pain control management **and notify** the **Anesthesiologist of patient's desire to have epidural/PCEA a**nesthesia.
   ~~1.~~**a.** The Nurse shall **give a brief history of the patient and her labor status to the Anesthesiologist using SBAR (Situation, Background, Assessment, Recommendation) format.**~~.~~
   ~~a.~~**b. Review** ~~Obtain~~ **the** results of **admission** ~~ordered~~ laboratory studies **and notify the Anesthesiologist of any abnormal findings.**~~.~~
2. **Obtain vital signs prior to anesthesia** placement **to establish baseline blood pressure (BP) and pulse.**
~~2. Notify the anesthesiologist for request of epidural.~~
3. Administer **a 500-1000 mL fluid bolus of Lactated Ringers prior to the placement of epidural/PCEA or spinal, per established Anesthesia orders.**~~Hydrate the patient prior to placement of epidural catheter with Lactated Ringers Solution; minimum 500-1000 mL/ or the amount ordered by the anesthesiologists.~~
   a. The ~~L&D R~~**nurse** shall verify obstetrician's order for the amount of hydration needed for patients on strict intake and output (-preeclampsia and/or a patient on magnesium sulfate).
4. Ensure an **epidural/PCEA** syringe **pump** is available **for use** once the **epidural is placed.**

C. **PROCEDURE:**

1. ~~Nurse will e~~**E**nsure all necessary equipment is at the bedside.
   a. **Obtain the** ordered medication **syringe from** the **Pharmacy**/ pyxis and have it available
2. **Prior to the procedure, the nurse and Anesthesiologist shall perform a procedural TIME OUT and document its completion in the** patient's **E**lectronic **M**edical **R**ecord (EMR).
   ~~3.~~
3. **Position the patient in a way that opens the spinal vertebra to assist with epidural placement.**
   a. Make sure she is lying or sitting on level surface, shoulders squared, with back rounded outward.
   b. Ensure she is supported, to prevent falling.
4. **Place a continuous pulse oximeter and blood pressure** (BP) **cuff on the patient.** Set the BP cuff to cycle **every 5 minutes during the** epidural/ spinal **placement process**
5. Monitor the Fetal Heart Rate according to the Fetal Heart Rate Surveillance Procedure.
6. **Once the epidural/PCEA or spinal is placed, assess BP, Pulse, Respiratory Rate and oxygen saturation levels at these intervals:**
   a. Every 2 minutes x 5
   b. Every 5 minutes x 3
   c. Every 15 minutes for duration of epidural infusion.
   ~~5. Nurse shall program the epidural infusion pump and have setting confirmed by the anesthesiologist.~~
   ~~a. Bupivicaine concentration as ordered~~
   ~~b. Rate in mL/hr.~~
   ~~c. For PCEA only: bolus amount in mL, Lockout time in minutes (1 hour maximum) in mL.~~
~~6. The RN shall assist the anesthesiologists with patient position for placement of epidural.~~
7. ~~If the patient will be utilizing the PCEA feature, the anesthesiologist will reinforce use of the infusion device as needed.~~ Ready the PCEA syringe pump for use:
   a. **Insert the** medication **syringe into the pump** and **verify that the selected guardrail medication dosing matches the Anesthesiologist's order** with the Anesthesiologist or a second nurse**..**
   b. **Once the** port less, yellow-striped, primed, epidural **tubing is attached to the epidural catheter by the Anesthesiologist,** the nurse shall **start the infusion and engage the lockout feature on the pump.**
8. **Monitor** for complications that may be associated with epidural insertion.

a. **Local Anesthetic toxicity:** Assess for drowsiness, light-headedness, tinnitus, circumoral paresthesia, metallic taste in mouth, slurred speech, blurred vision, unconsciousness, cardiac dysrhythmias and cardiac arrest. Notify anesthesia immediately if any of these symptoms are noted. Initiate cardiopulmonary resuscitation (CPRR) as needed.
b. **High Spinal:** Assess for numbness or weakness of the upper extremieties, dyspnea, weak speech or inability to speak, apnea and loss of consciousness. Notify anesthesia immediately if any of these symptoms is noted. Initiate CPR as needed.

9. Position the patient in lateral or upright position with uterine displacement using one of the following to maintain blood pressure and avoid hypotension.
   a. Hip wedge
   b. Semi-fowlers with uterine displacement
10. If hypotension o**O**ccurs**, utilize anesthesia order set to guide interventions and notify anesthesiologist**:
    a. ~~Position~~ **Place** the patient in lateral position
    b. Administer fluid bolus**, as ordered,** ~~and notify anesthesiologist.~~
    c. **Consider a**~~A~~dministration of ephedrine **if hypotension is not resolved with initial interventions ~~and~~ per Anesthesia orders.** ~~per department of anesthesia- Labor Analgesia PPO~~
    d. Notify obstetrician as necessary for significant unresolved hypotensive episodes.
11. Nurse shall advise the patient to notify the nurse for any unexpected sensations or loss of motor function following demand dose.
12. The lot number and brand of the epidural kit shall be documented in the Electronic Medical Record **(EMR)** by the ~~Rn~~ **nurse** assisting with the procedure
13. Assess and document adequacy of pain relief 30 minutes after placement and every 2 hours as needed.
14. ~~Initiate~~ **Place** Foley catheter **per order**~~to gravity drainage~~ within the first hour of epidural anesthesia.
15. **Monitor for the following side effects at a minimum every four hours:**
    ~~16.~~**a. Change in patient's level of consciousness**
    ~~a.~~**b. Nausea and vomiting**
    ~~b.~~**c. Itching, pruritus**

~~c.~~**16. Assess patient's dermatome level and motor function after initial epidural placement and once a shift at a minimum to establish baseline and/or** identify **changes.**

~~d.~~**17. Verify epidural catheter site is** intact; **infusion tubing is connected, labeled, and infusing on a dedicated infusion pump each shift.**

~~17.~~**18. Instruct the patient and family to:**
   a. **Avoid touching or manipulating catheter or tubing**
   b. **Avoid excessive moving around or overstretching upper extremities**
   c. **Notify the nurse if the catheter is accidentally removed or any part of it becomes disconnected.**

~~18.~~**19. At shift change,** the nurse shall review **and document the patient's pump history and total delivered doses with the oncoming nurse before clearing the pump history.**
   a. **The pump infusion settings should be reviewed against the Anesthesia orders with the oncoming nurse and documented in the patient's EMR.**

~~19.~~**20. The nurse may change the syringe containing the same medication and concentration, turn off the infusion and remove the catheter as ordered by the Anesthesiologist.** ~~If initial epidural infusion syringe needs replacing the nurse can replace the infusion syringe with pre-prepared solution containing the same medication as ordered by the anesthesiologist.~~

POST DELIVERY REMOVAL OF EPIDURAL OR INTRATHECAL CATHETER:

1. The Nurse will verify there is a written order to remove the catheter.
   a. If the patient is scheduled for a postpartum tubal ligation, the catheter should not be removed.
2. Place patient in relaxed position.

3. Assess patient for back pain, back tenderness and baseline motor strength and sensation prior to removal of the catheter.
4. Assess site for hematoma, drainage and signs of infection.
5. Stop infusion and clamp tubing.
6. Perform hand hygiene.
7. Remove dressing while maintain**in**g pressure on the tubing just above the insertion site. Do not use alcohol. (Alcohol is neurotoxic to epidural space)
8. Gently and steadily remove the catheter with one slow motion, while holding 2x2 gauze over the site.
   a. If patient develops pain or paresthesia or resistance is met, STOP procedure, place a sterile dressing over the site to secure the epidural line and notify the **A**~~a~~nesthesiologist.
9. Verify catheter tip is intact and rounded once catheter is removed.
10. If the tip is missing:
    a. Notify the physician
    b. Place the catheter with the missing tip in a specimen bag
    c. Label with the patient's name, date of removal
    d. Notify the shift supervisor.
11. Place sterile dressing over the areas and apply pressure for at least 2 minutes.
12. Evaluate patient's motor strength and sensation. Notify the **Anesthesiologist**~~physician~~ for decreased motor strength and/or se**ns**~~d~~ation that is not returning.
13. Document final syringe pump data history and w**aste unused medication per patient care services narcotic management program policy.**
14. ~~Document procedure and patient response.~~

E. **REFERENCES:**

1. **Association of Women's Health, Obstetric and Neonatal Nurses. (2012).The Role of the Registered Nurse (RN) in the Care of Pregnant Women Receiving Analgesia/ Anesthesia by Catheter Techniques (Epidural, Intrathecal, Spinal, PCEA Catheters) (Clinical Position Statement).Washington, DC:**
2. **Simpson, K. & Creehan, P. (2014). Perinatal Nursing,4th Edition. Philadelphia, PA.**
3. **Kennedy, B., Ruth, D., & Marin, E. (2009). Intrapartum Management Modules. A Perinatal Education Program, 4th Edition. Philadelphia, PA.**
4. **American Society of PeriAnesthesia Nurses. (2014) Position Statement 12, Care of the Perinatal Patient.**
5. **American Society of Anesthesiologists (2007). Practice guidelines for obstetric anesthesia: An updated report by the American Society of Anesthesiologists Task Force on Obstetric Anesthesia. Anesthesiology, 106, 843-863.**

~~1. Besuner, P. (2007) AWHONN Templates for Protocols and Procedures for Maternity Services. 2nd Edition. Washington D.C.~~
~~2. Cohen, S.P., Dragovich, A. (2007). Intrathecal Anesthesia. Anesthesiology Clinics, 25 (4). Retrieved December 2, 2008 from http://www.mdconsult.com.~~
~~3. Grant, P.J., Wesorick, D.H. (2008, March). Perioperative Medicine for the Hospitalized Patient. Medical Clinics of North America, 92(2). Retrieved December 2, 2008 from http://www.mdconsult.com~~
~~4. Gregoretti, C. et al (2007). Regional Anesthesia in Trauma Patients. Anesthesiology Clinics< 25(1). Retreived December 2, 2008 from http:// www.mdconsult.com~~
~~5. Perry, A.G>, Potter, P.A. (2006) Patient Controlled Analgesia. Clinical Nursing Skills and Techniques, 6th Edition. Retrieved December 2, 2008 from http://app32.webinservice.com/MosbySkills/SkillDetails~~

F. **RELATED DOCUMENT(S):**

1. **Women and Newborn Services Procedure: Fetal Heart Rate (FHR) Surveillance/Monitoring**
~~6.~~2. **Patient Care Services Procedure: Patient Controlled Analgesia (PCA)**

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**LAMINARIA**
Purpose:	To outline the nursing responsibilities in assisting the physician with the insertion and removal of Laminaria (Dilateria).
Supportive Data:	Laminaria is a sea grown plant, capable of absorbing fluids from uterine cervix. Gradual swelling of laminaria (up to 4 times its diameter) results in ~~aconcomitant~~ gradual symmetrical dilation of the cervical canal and soften~~sing~~ cervical tissue. Dilateria diameter swells the most within the first 4 to 6 hours after insertion~~. and may continue to swell~~. **It should be removed within 24 hours to prevent infection.** ~~for a total of ± hours.~~
Equipment:	1. Laminaria (Dilateria) 2. Vaginal speculum 3. Long ring forceps 4. Atraumatic tenaculum or a milex dilateria forceps (if available) 5. Antiseptic solution per physician preference 6. Cervical lubricant and sterile swabs 7. Light source 8. Sterile gloves 9. Gauze sponges

A. INDICATIONS FOR USE:

1. **Cervical ripening for first and second trimester miscarriage/ abortion**
2. **Dilates cervix in preparation for Dilation and Curettage (D&C) procedure**

B. CONTRAINDICATIONS:

1. **Laminaria should not be used when vaginal, cervical and/or pelvic infection is suspected**
2. **Laminaria should not be used if there is concern that the patient will not follow-up appropriately, as the patient must return within 24 hours to have it removed.**

~~A.~~C. INSERTION:

1. After **the** physician/**Allied Health Professional (AHP)** has in**formed** ~~structed~~ patient of **reasons for use,** risks and side effects, **the nurse should** verify ~~informed~~ **the patient's** consent.

~~2. Explain procedure to the patient.~~

~~3.~~**2. The nurse/ Obstetrical Technician (OB Tech) will ensure the** ~~Have~~ necessary equipment **is** available **to place the laminaria aseptically..**~~for physician.~~

~~4.~~**a. A staff member will retrieve the laminaria from the supply pyxis for insertion**~~Obtain laminaria from pharmacy.~~

~~5.~~**3. The patient should be encouraged to void prior to the insertion**~~Have patient void to empty bladder.~~

~~a. Increases accuracy of pelvic examination.~~

4. **The nurse and/or OB Tech will be available to help the physician prepare the patient for laminaria insertion by:.**~~Open gloves for physician and open packages with vaginal speculum, ring forceps, and gauze sponges.~~
   a. **Positioning the patient in lithotomy position for vaginal examination**
   b. **Having appropriate cleansing product available to perform a surgical preparation before laminaria insertion.**

~~6.~~**c. Assisting physician during the procedure with equipment needs.**

5. **The nurse shall document the size and number of laminaria placed and how the patient tolerated the procedure in a clinical note.**
6. **The nurse will complete patient education which should include but is not limited to discussion about:**

Department Review	Department of OB/GYN	~~Department of Pediatrics~~	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/03, 08/09	02/13, **08/16**	~~02/13~~	01/13, **11/16**	05/13, **11/16**	06/13, **01/17**	06/13

a. **Avoid bathing, douching, and intercourse while the laminaria is in place**
b. **The laminiaria needs to be removed within 24 hours. Patient must return to have it removed if is being sent home after the procedure**
   i. **IF the laminaria falls out, notify her doctor**
c. **Discomfort similar to menstrual cramping after placement may be felt**
~~7.~~**d.** **Call her doctor immediately if develops a fever over 100 F, chills, pain or vaginal bleeding while laminaria is still in place.** ~~Open package of cervical lubricant and swabs for physician~~.
~~8. Open package(s) of Laminaria as requested by physician.~~
~~9. Assist physician with additional instruments as needed.~~

D. CAUTIONS:

1. **Cervical manipulation may cause a vaso-vagal reaction in the patient. She should be watched for unusual pallor, nausea vertigo or weakness after placement and it is best to have her remain recumbent for three to 10 minutes after placement.**
2. **If laminaria remains in place for greater than 24 hours, the physician should consider antibiotic prophylaxis.**
3. **The laminaria should not be forced into place during insertion. If the cervix is obstructed the physician may have to pre-dilate the cervix for placement.**

~~B.~~E. REMOVAL:

1. **The nurse and/OB Tech shall h**~~H~~ave patient empty **her** bladder.
2. **The nurse and/or OB Tech will help p**~~P~~osition patient in bed for r**the** removal of laminaria.
3. **The nurse and/or OB Tech will get the required equipment**~~,~~ **and supplies to assist provider with removal.**~~Open sterile gloves, forceps, and tenaculum for physician~~ **to include**~~.~~ havinge **a** clean drape available on which to place **removed** laminaria.

~~3.~~**4. The nurse shall help get patient ready for surgery as needed.**

~~C.~~F. DOCUMENTATION:

1. At insertion **the nurse shall**~~,~~ note number and size of laminaria placed **by the physician.**~~and document in patient care record.~~
2. At removal, **the nurse shall** note number of laminaria removed **by the physician.** ~~and document in the patient record~~.

~~D. PATIENT TEACHING:~~

~~1. Avoid bathing, douching, and intercourse while laminaria is in place.~~
~~2. Must return within 24 hours for removal.~~
~~3. May feel discomfort similar to a menstrual cramp while laminaria is in place.~~
~~4. Report to physician if laminaria falls out. Have patient bring it when she returns.~~
~~5. Call physician immediately should patient develop fever over 100°F, chills, pain, or vaginal bleeding while laminaria is in place.~~
~~6. Use cervical medication if prescribed by physician.~~

~~7. Discharge patient per physician's orders.~~

~~E. CONTRAINDICATIONS:~~

~~1. Laminaria should not be used in the presence of a vaginal, cervical, and/or pelvic infection.~~
~~2. Laminaria should not be used if there is concern that the patient will not follow up appropriately.~~
~~a. The patient *must* return with 24 hours for removal of laminaria.~~

~~: CAUTIONS:~~

~~1. Laminaria should only be used in absence of infections or in "clean cases." Acute cervicitis or gonococcal infection should be treated before laminaria insertion is attempted.~~

2. ~~Any cervical manipulation may cause a vaso-vagal reaction. Patient should be watched for evidence of unusual pallor, nausea, vertigo, or weakness. By remaining recumbent for 3 to 10 minutes, these symptoms usually disappear.~~
3. ~~Do not reuse laminaria.~~
4. ~~Do not use any one laminaria for more than 24 hours and follow sterility and medication routines at each insertion. If laminaria is left in place more than 24 hours, proper prophylactic measures should be taken.~~
5. ~~Laminaria should not be forced into a seemingly obstructed cervix. If cervix is obstructed, the physician may have to pre-dilate cervix.~~

G. **REFERENCES:**

1. **Sagiv, R, Mizrachi, Y.,Glickman, H., Kerner, R., Keidar, R., Bar, J. and Golan, A. (2015). Laminaria vs. vaginal misoprostol for cervical preparation before second trimester surgical abortion: a randomized trial. Contraception. May:91 (5) 406-411.** ~~Package insert for Dilateria (Laminaria Japonica), Milex Products, Inc~~.

ISSUE DATE: 10/94 **SUBJECT:** SCHEDULING PROCESS FOR PROCEDURES

REVISION DATE: 1/00, 6/03, 8/09

Department Approval:	**06/16**
~~**Clinical Policies & Procedures Committee Approval:**~~	~~**02/13**~~
~~**Nurse Executive Committee Approval:**~~	~~**02/13**~~
~~**Medical** **Department of OB/GYN Approval:**~~	~~**08/09**~~**08/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**05/13**~~**01/16**
Professional Affairs Committee Approval:	~~**06/13**~~**01/17**
Board of Directors Approval:	**06/13**

A. **CESAREAN SECTIONS:**

1. Scheduling:
   a. Obstetricians' **(OB)** offices will call T**ri-**C**ity** M**edical** C**enter (TCMC)** main surgery scheduling at 760-940-7382 to schedule surgical procedures in Labor and Delivery **(L&D)** O**perating** R**oom (OR).**
      i. Only **three**~~3~~ cases are to be scheduled each day
      ~~i.~~**ii. No elective surgeries are scheduled on the weekends, if avoidable.**
   b. Add-on cases for **m**~~M~~aternal or **f**~~F~~etal medical indications~~,~~ or elective bilateral tubal-ligations (for sterilization), may be scheduled through the **Assistant Nurse Manager (ANM) or designee.** ~~shift supervisor/charge nurse.~~
   c. Required information at the time of scheduling **shall include**:
      i. Primary Surgeon and Assist
         1) Name of the ~~elective or~~ indicated procedure
         ~~1) Pediatrician or use of Neonatologist if applicable~~
         2) Patient name, Age, **Estimated** Gestational Age **(EGA)** in weeks
            ~~2)~~**a) IF under 39 weeks EGA at the time of the scheduled procedure, there must be a valid medical indication. See Elective Delivery under 39 weeks unit specific policy** ~~(if applicable)~~
         ~~2)~~**3)** Patient's Gravida ~~(number of pregnancies)~~ and Para ~~(number of living children)~~
         ~~3)~~**4)** Reason for **procedure** ~~Cesarean Section~~
         ~~4)~~**5)** Significant medical problems/history, e.g. Hypertension, Low A**mniotic** F**luid Index** (oligo), Diabetes, known fetal problems or anomalies
   d. The **ANM/ designee** ~~shift supervisor/charge nurse~~ shall review ~~daily~~ the OR schedule in Cerner to ensure accuracy and ~~to~~ check the delivery log for those patients who have already delivered **to update schedule as indicated**.

2. Elective Cases:
   a. ~~Selected patients be k~~**K**nown candidates for cesarean section**s** ~~and~~ will have their surgeries scheduled in advance. **The most common examples include, but are not limited to:**
      i. Progression of pregnancy related hypertension/preeclampsia with changes in baseline labs
      ii. Uncontrolled diabetes
      iii. Known placenta previa
      iv. Previous classic uterine incision

v. Known fetal anomalies where cesarean section may improve later motor or mechanical function

vi. Maternal/fetal indication with associated oligohydramnious not conducive to the labor process

vii. Maternal or fetal condition requiring intervention per perinatal or neonatal consultation

~~a.~~**b.** The **OB ~~provider~~physician/Allied Health Professional (AHP)** ~~physician~~ and/or a representative from the ~~**provider**~~**physician/AHP's** ~~hysician's~~ office will contact the surgery scheduling office at T**CMC.**~~ri-City Medical Center~~.

i. If another procedure will occur with the cesarean section, (e.g. tubal ligation), this needs to be indicated in the **scheduling calendar.**~~calendar~~.

ii. The patient will also be scheduled for pre-op teaching.

~~b.~~**c.** Scheduled cases are usually limited to three per day at 0730, 0900, and 1200.

~~a.~~**d.** Cases are scheduled on a first-come, first-served basis.

~~c.~~**e.** If a patient scheduled for a cesarean section delivers prior to her scheduled surgery date, it is the responsibility of the Clinic/ **~~Provider~~Physician/AHP's** ~~Physician's~~ office to **notify the** OR **Surgery scheduling center** to have her name ~~removed~~**removed, when possible.** ~~from the scheduled procedures scheduling calendar~~. This will allow the schedule to be **updated and the scheduled slot opened**~~accessible~~ for other requests**.** ~~by the medical staff~~.

~~3. Medical Indications:~~

~~a. For any cases where there are maternal or fetal concerns not requiring same day or urgent intervention, yet have the potential for compromise should be added to the schedule of the L&D OR by the physician through the shift supervisor/charge nurse.~~

~~i. The shift supervisor/charge nurse shall determine availability of OR suite in L&D or the main OR~~

~~b. Most common examples include, but are not limited to:~~

~~ii. Progression of pregnancy related hypertension/preeclampsia with changes in baseline labs~~

~~iii. Uncontrolled diabetes~~

~~iv. Know placenta previa~~

~~v. Previous classic uterine incision~~

~~vi. Known fetal anomalies where cesarean section may improve later motor or mechanical function~~

~~vii. Maternal/fetal indication with associated oligohydramnious not conducive to the labor process~~

~~viii. Maternal or fetal condition requiring intervention per perinatal or neonatal consultation~~

3. Pre-op Visit:

a. **Shall be scheduled according to unit policy to** ~~Scheduled the day before the case through the main OR, preferably by 1500 to~~ allow for processing of pre-op labs/diagnostic tests

b. Pre-op teaching will be ~~initiated on the day before the case is scheduled and~~ completed by the ~~admitting~~ L&D **nursing staff.**~~RN on the day of surgery.~~

B. **INDUCTIONS:**

1. Elective Inductions:

a. Selected patients may be scheduled by their **OB ~~provider~~physician/AHP**~~physician~~ for an induction of labor **when greater than 39 weeks of gestational age**

b. The **OB physician/AHP**~~physician~~ and/or representative from the physician's office will contact the **L&D ANM or designee**~~labor and delivery shift supervisor/charge nurse~~ **to add the patient to the department's schedule**.

~~ix.~~**i.** The **patient** information **should include the patient's:**

~~x.~~**1) Name**

~~xi.~~**2) Patient birthdate**

~~xii.~~**3) Estimated Due Date/ EGA**

~~xiii.~~**4) Reason for induction**

~~1)~~**5) ~~Provider~~Physician/AHP**

~~2)~~**6) Patient's phone number** ~~will be entered into the scheduled procedures scheduling calendar~~.

ii. **The Office will fax the patient's prenatal record to L&D.**

c. Generally, patients should be instructed to call **L&D**~~labor and delivery~~ one-two hours before their scheduled induction to ensure room and staff availability to safely proceed with the induction. This will also decrease the number of patients sitting in the waiting area for prolonged periods of time and improve patient satisfaction.

d. If a scheduled induction patient fails to keep appointment**, it should be determined if the patient has already delivered and attempts made to contact the patient.**

~~b. C.,~~ **if** ~~the labor and delivery log and/or scheduled procedures scheduling calendar should be checked to see if she has already delivered.~~

i. If there is no indication that the patient has ~~been~~ delivered **and the patient cannot be contacted,** ~~,~~ the **OB** ~~**provider**~~**physician/AHP** ~~physician or physician's representative~~ **shall be** ~~is~~ notified. ~~that the patient did not keep her appointment.~~

2. Medically Indicated Inductions:

a. Unscheduled inductions may occur due to **newly acquired** medical indications.

~~ii.~~**i. These patient admissions are coordinated** ~~Scheduled~~ **directly with the L&D ANM/ designee** on an as needed basis by the **OB** ~~**provider**~~**physician/AHP.** ~~physician with the L&D shift supervisor/charge nurse~~.

~~iii.~~**ii.** Medical indications are not elective procedures, but are considered necessary for maternal or fetal concerns requiring intervention by the **OB** ~~**provider**~~**physician/AHP**~~obstetrician~~ or as a result of a perinatal/neonatal consult.

~~iv.~~**iii.** Staffing availability will need to be **allocated to support these admissions and some elective inductions may need to be delayed depending on unit census and nursing ratio requirements.** ~~considered for the timing of medically indicated exceptions based upon:~~

~~1) L&D RN~~

~~2) LDRP room available~~

C. **POSTPARTUM TUBAL LIGATIONS:**

1. Elective tubal ligation after a vaginal delivery will be scheduled by the **OB** ~~**provider**~~**physician/AHP**.~~attending physician~~.

~~a. Both the TCMC surgery scheduling office and the L&D shift supervisor/charge nurse will be notified.~~

~~b.~~**a.** Elective tubal ligations will be **added to** ~~scheduled in~~ the **department procedure** calendar **at a proposed time around the scheduled procedures, to ensure L&D staffing is available to support the case in the L&D OR.** ~~based on the number and scheduled times of cesarean sections~~.

~~c.~~**b.** Elective tubal ligations **that cannot be scheduled during the patient's stay may be scheduled as an outpatient procedure during her postpartum visit.** ~~may be added by the shift supervisor/charge nurse to the main OR schedule if the L&D Operating suites are unavailable for elective procedures. The add-on elective procedure will follow the main OR's priority list for non-scheduled emergent surgeries.~~

~~c. All elective tubal ligations will be placed in the calendar with the following information:~~

~~i. Patient's name~~

~~ii. Physician~~

~~iii. Time~~

D. **OUTPATIENT PROCEDURES:**

1. Certain patients **may be**~~will be~~ scheduled to come to **L&D** ~~labor and delivery~~ for a variety of outpatient procedures. These procedures include but are limited to:

a. Antenatal testing

b. Amniocentesis

c. External cephalic version

~~c.~~**d. Laminaria insertion**

2. The **OB** ~~**provider**~~**physician/AHP**~~physician~~ and/or a representative from the ~~physician's~~ **clinic**~~office~~ will contact the **L&D ANM/designee.** ~~labor and delivery shift supervisor/charge nurse.~~
   a. The information will be entered into the scheduled procedures ~~scheduling~~ calendar.
   b. In addition to the patient's name, the procedure, the date and time, **and** a phone number for the patient will also be entered in the calendar.
   c. Patient will be instructed to call **the L&D unit** one-two hours prior to procedure time to ensure ~~anticipated time is feasible and~~ a room and nurse are available**.**

E. **OUTPATIENT REGISTRATION:**

1. Patients coming to T**CMC**~~ri-City Medical Center~~ for procedures on the **L&D** ~~labor and delivery~~ unit will be instructed to check in with the admitting clerk or unit secretary at the front reception desk in W**N**~~C~~S.
   ~~iv.~~**a.** The admitting clerk will register the patient in the hospital information system

ISSUE DATE: 10/94 **SUBJECT:** Shift Change Responsibilities

REVISION DATE: 01/00, 06/03, 07/06

Department Approval:	03/16
Department of OB/GYN Approval:	n/a
Division of Neonatology Approval:	n/a
Department of Pediatrics Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	01/17
Board of Directors Approval:	06/13

A. **ASSIGNMENT SHEET:**

1. Patient care assignments are made by the charge nurse for the oncoming shift.
   a. The names of ~~licensed~~ nursing personnel working in labor and delivery (L&D), ~~newborn nursery,~~ and mother-baby **unit** ~~couplet~~ are listed on the assignment sheet for women~~'s~~ and **newborn** ~~children's~~services **(WNS)**.
   b. Support staff and management personnel assigned to each of the areas is also documented.
2. The assignment sheets are maintained by the charge nurse.
   a. Nurses may obtain their assignments from the unit census boards.
3. **Updates**~~Changes~~ to the assignment sheet, indicating admissions and/or discharges are made by the charge nurse on an ongoing basis during the shift.

B. **SHIFT REPORT:**

1. **N**~~Licensed~~ nursing staff, unlicensed staff, and management personnel **receive**~~take~~ report from the off-going shift.
   a. This report is given verbally **and if possible at the patient's bedside**.
   b. Report is to be given in a manner that protects patient confidentiality.
2. Management report is given in an in-person verbal format at 0700 and 1900 between the oncoming and off-going charge nurses.
3. During report, specific patient condition information and anticipated needs are discussed.
   a. All concurrent and prospective interventions are based on the plan of care for each patient.

C. **PLAN OF CARE:**

1. The plan of care is formulated by the ~~registered~~ nurse using information gathered from the **patient history and current clinical assessment.** ~~WCS database.~~
   a. The plan of care is ~~formulated~~ and interventions are **reviewed and discussed with the patient and should reflect items to help the patient meet established outcomes.** ~~identified for problems that are common to our population.~~
   b. **The plan of care should be curtailed to meet the needs of the patient and may change during the patient's stay.** ~~Unique problems of specific individuals are also noted and interventions are formulated.~~

~~1. Non-registered nurse staff, (e.g. licensed vocational nurses) may have various components of problem interventions assigned by a registered nurse.~~

2. Interventions for problems identified are evaluated **and/or updated**~~after the time frame specified in the plan of care or~~ at least every 24 hours.

3. All care planning is **coordinated** ~~done~~ by the registered nurse**.** ~~alone or in conjunction with an LVN.~~
   a. **Acute Care Technicians (ACT's) or Certified Nursing Assistants (CAN's)**~~LVN's~~ assist the ~~registered nurse in care planning~~ by providing data gathering **tasks**~~assistance~~ and ~~performing tasks/~~duties assigned to him/her by the registered nurse.

~~2. Registered nurse staff function as charge nurse and primary care planners for a specific group of patients.~~

~~a. **Acute Care Technicians (ACT's) or Certified Nursing Assistants (CNA's)**LVNs assist the registered nurse in care planning by providing data gathering **tasks**assistance and performing tasks/duties assigned to him/her by the registered **nurse.**d nurse.~~

D. **ROLES OF SUPPORT PERSONNEL:**

1. OB Technicians **(Techs):**
   a. ~~OB technicians (techs)~~ ~~f~~**F**unction as support personnel to the **medical and** ~~licensed~~ nursing staff and perform tasks that are assigned to them **which can include but is not limited to:**
      i. Surgical scrub technician role
      ii. Assist with delivery room set up, management, and any equipment preparations~~.~~
      iii. Instrument cleaning preparations
      iv. Sterile processing department duties
      v. Patient transfer/transport
      ~~b.~~**vi. Supply and room stocking role**
2. Unit Secretaries**:**
   a. ~~Unit secretaries p~~**P**rovide clerical support to nursing staff **and medical staff**~~as well as physicians~~ in the areas that comprise **WNS**~~women's and children's services~~.
3. **Peri-Operative Aides:**
   a. Function as housekeeping support personnel to the L&D unit and perform tasks that are assigned to them which can include but is not limited to:
      i. All housekeeping duties to include operating room terminal cleaning
      ii. Patient transfer/ transport
      ~~c.~~**iii. Specimen transport**

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**VACUUM EXTRACTION**
Purpose:	Provide procedural guidelines for the RN assisti
Supportive Data:	A vacuum extractor consists of a soft or rigid cup suction device attached. This device is used as the fetal head. The cup is placed on fetal head, seal is formed. Gentle traction is then applied to deliver the fetal head.
Equipment:	1. Fetal monitor 2. Vacuum extractor and tubing 3. Vacuum hand pump with gauge

DELETE – use Mosby's, it is inclusive of the correct practice elements

A. **POLICY:**
1. Application and management of vacuum cup by Physician only.
2. Assistance with pump by an RN or Physician.

B. **INDICATIONS FOR USE:**
- a. Fetal:
  - i. Non-reassuring fetal tracing.
  - ii. Failure to deliver spontaneously following an appropriately managed second stage.
- b. Maternal:
  - i. Need to avoid voluntary expulsive efforts.
  - ii. Inadequate expulsive efforts.

C. **CONDITIONS/CONSIDERATIONS FOR USE:**
- a. Complete dilation and effacement of the cervix.
- b. Engaged fetal head is at station 0 or more
- c. Ruptured amniotic membranes.
- d. Empty bladder and rectum.
- e. Greater than 34 weeks gestation.

D. **CONTRAINDICATIONS FOR USE:**
- a. Manual rotation of the fetal head.
- b. Incomplete dilation of cervix.
- b. Face, brow, breech presentation or transverse lie.
- b. Unengaged vertex.
- c. Suspected macrosomia.
- d. Prematurity ≤ 34 weeks gestation.
- e. Cephalopelvic disproportion.
- f. Previous scalp sampling (relative contraindication).
- g. Suspected fetal bleeding abnormalities.
- h. Failed vacuum extraction if any of the following exist:
  - i. Cumulative traction time exceeds 10 minutes, or 15-30 minutes total procedure time.
  - ii. Extractor cup becomes disengaged ("pop-off") three times with good application to fetal scalp, as defined by the physician.
  - iii. Vertex has not advanced substantially with each traction attempt.
  - iv. Evidence of fetal scalp trauma.

E. **PROCEDURE:**
1. Monitor FHR during procedure.

Review/Revision Date	Clinical Policies & Procedures	Patient Care Quality Committee	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors Approval
5/09, 05/16			6/09, 08/16	n/a	10/16	01/17	7/09

2. Gather equipment:
   a. Pump assembly with gauge.
   b. Sterile tubing and sterile extractor cup with traction handle or preassembled suction cup and tubing.
3. Place sterile equipment on delivery table.
4. Connect the tubing to the pump "nipple"/assembly after MD hands off end of sterile tubing.
5. The physician confirms the vacuum pressure by placing a sterile-gloved hand over the suction cup and squeezing the trigger to apply 100 mmHg of pressure (green zone).
6. When the physician indicates that the cup has been placed over or near the posterior fontanel, raise the vacuum pressure to the yellow zone to initiate adhesion.
7. As contraction begins, the physician or RN assist will raise the vacuum pressure to the **green zone** (500 mmHg). A consistent level of pressure should be kept, using traction on the vacuum extractor to assist with the delivery of the head.
8. When the physician determines the contraction is no longer effective, reduce the vacuum pressure to the **yellow zone** and await the next contraction. Pressure should remain steady.
9. Document each increase and decrease in OB TraceVue. Notify the physician of the amount of time that has been accrued at maximum level. The vacuum should not remain at maximum levels for more than 10 **cumulative** minutes, or 15-30 minutes total procedure time.
10. Document in OB TraceVue: station, number of attempts, time lapsed during procedure, FHR, and type of suction used. Physician to document the number of pop-offs in the patient's medical chart.
11. Notify the RN caring for the newborn that a vacuum assist was used.
12. Notify the Pediatrician that a vacuum assist was used when routine notification of the birth is done.
13. Document the vacuum assist in the Maternal Delivery summary and Newborn Admission records.

F. **REFERENCES:**

1. AAP & ACOG. (2007). Guidelines for Perinatal Care, 6th Edition
2. American College of Obstetricians and Gynecologists. (2006b). Operative vaginal delivery. Clinical Management Guidelines. Washington, DC: Author
3. Caughey, A. B., et al. (2005). Forceps compared with vacuum: Rates of neonatal and maternal morbidity. Obstetrics and Gynecology, 106 (5, Part 1), 908-912.
4. MityVac Manufactures Guidelines for 10007LP M-Style® Mushroom® Cup (2006, November)
5. Royal College of Obstetricians and Gynaecologists. (2005, October). Operative vaginal delivery. Retrieved February 2, 2009 from http://www.guideline.gov
6. Olds, S. B., London, M. L., Wieland-Ladewig, P. A., & Davidson, M. R. (2004). Maternal-Newborn Nursing & Women's Health Care (7th ed.). Upper Saddle River, NJ: Pearson Education, Inc.
7. Simpson, K. R., & Creehan, P. A. (2008). AWHONN Perinatal Nursing (3rd ed.). Philadelphia, PA: Lippincott-Raven Publishers.
   i. Vacca, A. (2002). Vacuum assisted delivery. Best Practice & Research: *Clinical Obstetrics and Gynaecology*, 16(1), 17-30;
   ii. Castro, M. A. et al., (2003). Controversies in the use of the vacuum extractor. *Seminars in Perinatology*, 27(1), 46-53

Formulary Line Item Additions/Deletions

Deletions:

- Albuterol tablets
- Erythromycin/sulfixoxazole 200mg/600mg suspension
- Formoterol 12 mcg (Foradil Aerolizer)

Albuterol tablets

Oral route is not guideline recommended. Stocked albuterol tablets and syrup formulations routinely expire. Oral syrup formulation removed from formulary per P&T decision in September. Preferred treatment route is via inhalation (nebulized or through inhaler).

Erythromycin/sulfisoxazole 200mg/600mg suspension

Erythromycin/sulfisoxazole was a macrolide combination used for the treatment of otitis media in pediatric patients. This product was withdrawn from the US market over a year ago and is no longer available from wholesalers.

First line treatment for otitis media in pediatric patients includes amoxicillin or amoxicillin/clavulanate. Alternative agents include cefdinir, cefpodoxime, cefuroxime, ceftriaxone, and azithromycin.

Formoterol 12 mcg (Foradil Aerolizer)

Formoterol 12 mcg capsule (for use with Aerolizer inhaler) is no longer manufactured. Formoterol nebulized solution (Perforomist®) is available on the TCMC formulary.

TRI-CITY MEDICAL CENTER
PHARMACY AND THERAPEUTICS COMMITTEE

Request for Formulary Status Evaluation:

Admission { x } **Deletion { }**

Date: 11/16/2016 **Requestor:** Dr. Oska Lawrence

Trade Name: Zarxio **Generic Name:** Filgrastim-sndz

Dosage form(s): 300 mcg/0.5 mL and 480 mcg/0.8mL single-use prefilled syringe injection
Indications:

1. Neutropenia, in patients with nonmyeloid malignancies receiving myelosuppressive anticancer drugs, undergoing myeloablative chemotherapy followed by bone marrow transplantation (BMT), or due to congenital or idiopathic causes
2. Neutrophil recovery, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia (AML)
3. Leukapheresis; mobilization of autologous hematopoietic progenitor cells into the peripheral blood

Efficacy:
The comparison of the analytical properties of filgrastim-sndz and filgrastim (Neupogen®) concluded the agents were highly biosimilar, notwithstanding minor differences in clinically inactive components. The results of the PK and PD similarity studies for doses studied (1, 2.5, 5 and 10 mcg/kg) support no clinically meaningful differences in the efficacy for all of the indications for which filgrastim (Neupogen®) is approved. The efficacy results of Cycle 1 of the filgrastim-sndz EP06-302 study, carried out in patients with breast cancer receiving chemotherapy, demonstrated **non-inferiority**. The safety analysis from this same randomized clinical study did not show any associations for new safety signals. Originator filgrastim (Neupogen®) and biosimilar filgrastim (Zarxio™) have the same indications, dosing recommendations, and dosage formulations.
Safety:

Propensity for medication error: Low

Abuse potential: None

Sentinel event potential:

1) Immunogenicity – antibody development a theoretical risk however incidence for filgrastim has never been determined

Cost comparison with similar Formulary products:

	300mcg	***480mcg***	
Neupogen®	$267.70/vial	$426.30/vial	
Zarxio®	$165.40/PFS	$263.40/PFS	
# of Neupogen® doses dispensed May 2015-May 2016	231 ($61,838.70)	234 ($99,747.18)	
Annual potential cost savings with Zarxio®	**$23,631.30**	**$38,111.58**	**Total = $61,742.88**

Recommendation:

Pharmacy Service recommends addition of Zarxio (filgrastim-sndz) to the TCMC formulary to replace Neupogen (filgrastim) Recommend removal of Neupogen® from TCMC formulary

Recommend modification of the Pharmacy Automatic Therapy Interchange Procedure to provide pharmacists the ability to automatically convert patients to Zarxio (filgrastim-sndz) if Neupogen (filgrastim) is ordered

- Interim P&T approval to make conversion following formulary approval of Zarxio®

Recommend education to nursing staff regarding Zarxio's relationship to Neupogen, changes in product appearance, and administration procedures

Process/Plan to monitor Patient Response:

1. Monitor white blood cell count
2. Monitor for immunogenicity

References:

1. Food and Drug Administration Approves First Biosimilar Product Zarxio. March 6th, 2015.

2. Zarxio® [package insert], Princeton, NJ: Sandoz Inc. 2015.

3. Neupogen ® [package insert], Thousand Oaks, CA: Amgen Inc. 1991.

4. Aapro M, Cornes P, Abraham I. Comparative cost-efficiency across the European G5 countries of various regimens of filgrastim, biosimilar filgrastim, and pegfilgrastim to reduce the incidence of chemotherapy-induced febrile neutropenia. J Oncol Pharm Pract. 2012 Jun;18(2):171-9.

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
January 3, 2017

Members Present:	James J. Dagostino, DPT, PT, Chairperson; Director Laura E. Mitchell, Director RoseMarie V. Reno; Dr. Cary Mells, Physician Member; Dr. Gene Ma, Chief of Staff
Non-Voting Members:	Steve Dietlin, CEO; Kapua Conley, COO; Cheryle Bernard-Shaw, Chief Compliance Officer
Others Present:	Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Robin Iveson, Community Member; Greg Moser, General Counsel
Absent:	Dr. Paul Slowik; Community Member; Eric Burch, Community Member; Dr. Marcus Contardo, Physician Member

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino.		
2. Approval of Agenda	Director Reno requested agenda item 6 d. Review and discussion of Board Policy 16-044 – Distribution of Tickets and Passes to District Sponsored or Controlled Events and Donated Tickets and Passes be pulled from the agenda as the updated policy has addressed her previous concerns. **It was moved by Director Reno to approve the agenda as amended. Director Mitchell seconded the motion. The motion passed unanimously.**	Amended Agenda approved.	
3. Comments from members of the public	Chairman Dagostino read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Reno and seconded by Dr. Ma to ratify the minutes of the September 6, 2016 Governance & Legislative Committee. The motion passed with Director Mitchell abstaining from the vote.**	Minutes ratified.	Ms. Donnellan
5. Old Business			

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
a. Review and discussion of Committee Charter 1) Governance & Legislative Committee	The committee reviewed the proposed revisions to the Governance & Legislative Committee Charter. Director Reno suggested the word "review" remain in section I. 1. c. Mr. Moser referred Director Reno to the language in Section I. 1. It was determined 1.c was correct as written. With respect to review of the Charter, Director Reno requested the language be added to include "or as necessary". Chairman Dagostino entertained discussion related to the number of Community Members on the Committee. Director Reno stated in the past, four (4) community members were selected to cover potential absences. Mr. Moser stated feedback from past community members indicated they did not feel they could provide much feedback to discussions of the committee. It was suggested the posting for the community openings include a description of what the committee is responsible for. Mr. Dietlin suggested membership be listed as a minimum of three (3) but no more than four (4). Committee members were in agreement with this recommendation. **It was moved by Director Reno to recommend approval of the Governance & Legislative Committee Charter with amendments as described. Director Mitchell seconded the motion. The motion passed unanimously.**	Direct staff to include a summary of scope of responsibility for the applicable committee when placing ads. Recommendation to be sent to the Board of Directors to approve the Governance & Legislative Committee Charter with revisions as described; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan Ms. Donnellan
6. New Business a. Medical Staff Rules & Regulations: 1) Division of Subspecialty Surgery	Dr. Ma reported the Division of Subspecialty Surgery Rules & Regulations have been reformatted for consistency with other Rules & Regulations. Discussion was held regarding Section 7. C related to concurrent or retrospective chart review of cognitive processes. Dr. Ma clarified concurrent review is done for invasive procedures and retrospective chart review of cognitive processes.	Recommendation to be sent to the Board of Directors to approve the Division of Subspecialty Surgery Rules & Regulations; item to be placed on Board agenda and included in agenda packet.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	A formatting issue was also noted in Section VII. Director Reno questioned if Podiatrists should be included. Dr. Ma stated he believes Podiatrists are addressed in another Division's Rules & Regulations but will follow-up to ensure they are being addressed. **It was moved by Director Reno to recommend approval of the Division of Subspecialty Surgery Rules & Regulations as described. Director Mitchell seconded the motion. The motion passed unanimously.**		
b. Review and discussion of Committee Charter: 1) Finance Operations & Planning Committee	The committee reviewed the Finance, Operations & Planning Committee Charter. There were no revisions suggested to the Charter. **It was moved by Director Mitchell to recommend approval of the Finance, Operations & Planning Committee agenda as presented. Director Reno seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve the Finance, Operations & Planning Committee Charter as presented; item to be placed on Board Agenda and appear in agenda packet.	Ms. Donnellan
2) Employee Fiduciary Subcommittee	The committee reviewed the Employee Fiduciary Subcommittee Charter. Director Mitchell requested clarification on the ERISA provision. Mr. Moser stated the ERISA provision does not apply to the District due to the fact we are a governmental agency. Discussion was held regarding membership of the Employee Fiduciary Subcommittee and whether three (3) Board members should serve on the Subcommittee, similarly to other Board committees. Mr. Moser stated membership is under the jurisdiction of the Human Resources Committee. Director Reno recommended the Human Resources Committee appoint a third Board member (Director Grass) to the Employee Fiduciary Subcommittee.		

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	It was moved by Director Mitchell to recommend approval of the Employee Fiduciary Subcommittee Charter as presented and direct the Human Resources Committee to consider appointing Director Grass to the Employee Fiduciary Subcommittee. Director Reno seconded the motion. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve the Employee Fiduciary Subcommittee Charter as presented; item to be placed on Board Agenda and appear in agenda packet. Direct Human Resources Committee to consider appointment of Director Grass to the Employee Fiduciary Subcommittee; item to be placed on next Human Resource Committee agenda.	Ms. Donnellan Ms. Donnellan
c. Review and discussion of Board Policy 14-009 – Requests for Information or Assistance by Board Members	Director Reno stated Board Policy 14-009 – Requests for Information or Assistance by Board Members was placed on today's agenda to discuss how information is communicated as a result of a Director's request for information. Mr. Moser explained the policy specifically addresses requests for information by Board members in various circumstances and who those requests should be directed to. Mr. Dietlin stated the policy is essential for voluminous requests that require a significant amount of staff time to compile. Following further discussion the committee concurred the policy addresses these concerns as written and did not recommend any additional changes. **It was moved by Director Reno to recommend approval of Policy 14-009 – Requests for Information or Assistance by Board Members as written. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 14-009 – Requests for Information or Assistance by Board Members as written; item to be placed on Board Agenda and appear in agenda packet.	Ms. Donnellan
d. Review and discussion of Board Policy 16-044 – Distribution of Tickets and Passes to District Sponsored or Controlled Events and Donated Tickets and Passes	Board Policy 16-044 – Distribution of Tickets and Passes to District Sponsored or Controlled Events and Donated Tickets and Passes was pulled from the agenda.	None.	

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e. Review and discussion of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson	Director Reno stated Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson was placed on today's agenda to discuss agenda development and placement of items on the Consent Agenda. Mr. Moser explained items that come before the Board are controlled by statute. The Consent agenda was implemented as an efficient way to do business. The question was raised as to who decides which items are placed on the Consent agenda rather than under new Business. Mr. Moser stated that determination is made at the agenda conference which is attended by General Counsel, Mr. Dietlin, the Board Chair and the Executive Assistant. The question was also raised as to whether any Board member can attend the agenda conference. Mr. Moser stated Board members are not prohibited from attending the agenda conference however their role would be strictly as a guest and per the Brown Act there cannot be a quorum of Board members at the agenda conference. Discussion was held regarding the ways in which items on the Consent Agenda can be open for discussion. 1) Items that appear on the Consent Agenda have gone to the applicable Board Committee during the current month. Board Committee packets are sent to all Board members whether they sit on the committee or not and the entire packet is also posted on the District's website for public purview. 2) Board committee meetings are open to public where agenda items are discussed in detail. 3) Recommendations for approval from the Board Committees are brought forward to the Board as a whole and placed either on the Consent Agenda or New Business at the discretion of the Chair. 4) The entire Board packet is posted on the District's website at least 72 hours prior to the meeting for public purview. If further discussion is desired on a Consent Agenda item, the Board member has the ability to pull the item with a "second" for discussion. In addition, community members may complete a Speaker Card to comment on		

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	any item on the agenda. **It was moved by Director Reno to recommend approval of Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson as written and placed under New Business on the Board agenda. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 16-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson; item to be placed on Board Agenda New Business and included in Board agenda packet.	Ms. Donnellan
f. Review and discussion of Board Policy 16-040 – Activities for Which Board Compensation is Available	Director Reno stated she requested Board Policy 16-040 – Activities for Which Board Compensation is Available be placed on today's agenda to discuss a potential stipend for Board member attendance at the designated Auxiliary and Foundation monthly Board meetings. Director Reno stated the designated Board member attends the Auxiliary and Foundation Board meeting as an advisory party, rather than a guest and therefore should be compensable. It was noted attendance by Board Members at MEC would not be compensable as the Board member is purely a guest. It was suggested the policy be revised to reflect that "attendance at meetings of the Tri-City Hospital Auxiliary and Tri-City Hospital Foundation at the request of the Chair of the Board shall be compensated, provided that the meeting is at least 30 minutes in length, the Director is physically present during the meeting for not less than 30 minutes and further provided that compensation is limited to fifty ($50) per meeting". Discussion was held regarding reimbursement for participation via teleconference. Mr. Moser stated no compensation is provided via teleconference from a location which is not a location open to the public per the Brown Act and within the jurisdiction. **It was moved by Dr. Ma to recommend approval of amendments to Board Policy 16-040 – Activities for Which Compensation is Available as described. Director Reno seconded the motion. The motion**	Recommendation to be sent to the Board of Directors to approve amendments to Board Policy 16-040 – Activities for Which Compensation is	Ms. Donnellan

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	passed unanimously. It was recommended amendments to Board Policy 16-040 be placed on the New Business section of the February Board agenda rather than the Consent Agenda.	Available; item to be placed under New Business on Board agenda and included in agenda packet.	
g. Review and discussion of process for assuming office	Director Reno stated she placed discussion of process for assuming office on today's agenda as she believes there should be a formal standard process that is followed for new and re-elected Board members that are sworn in. Director Reno expressed her appreciation for General Counsel's memorandum that reflected the laws regarding the swearing in of public officials. Director Reno also commented that community members were disappointed in the lack of appetizers at the Swearing In Ceremony and physicians commented on the lack of a formal invitation to the swearing in. Mr. Moser explained the same rule applies to all government officials. The office holder is required to sign the oath of office and said oath must be witnessed and filed in the office of the clerk or secretary of the District. Mr. Moser's memorandum explained the various individuals who are qualified to administer the oath. There is no legal requirement with regards to a formal ceremony. Chairman Dagostino questioned if there is no legal requirement for a celebration ceremony is it an abuse of public funds to provide refreshments. Director Reno suggested Procopio's memorandum be followed in the future for administering the Oath of Office and the selection process for choosing an individual to administer the oath should be agreed upon by those being sworn in rather than the Board Chair. Mr. Moser commented that the swearing in process has been handled traditionally on an ad hoc basis and there have not been any issues in the past. It was recommended today's committee minutes be retained by the Executive Assistant for reference in	Procopio's memorandum of December 21, 2016 related to "Laws Regarding the Swearing in of Public Officials" will be retained along with today's committee minutes for reference in future election years.	Ms. Donnellan

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	future election years.		
7. Discussion regarding Current Legislation	Director Reno stated she is concerned how the new healthcare laws will affect reimbursement from our patients in the Emergency Department. Dr. Ma stated he expects to see some reductions in payment.		
8. Review of FY2017 Board Work Plan	Chairman Dagostino stated a draft Work Plan will be developed based on the Charter.	Draft Committee Work Plan to be added to the February agenda.	Ms. Donnellan
9. Committee Communications	Chairman Dagostino reminded committee members of the Ethics & Compliance Training session scheduled for February 2, 2017. He explained AB1234 mandates every committee member complete two hours of Ethics Training every two years as designated by District Policy.	AB1234 Ethics & Compliance Training scheduled for February 2, 2016. RSVP to Teri Donnellan.	
10. Committee Openings – Two	There are currently two openings on the committee		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, February 7, 2017 at 12:30 p.m.	The next meeting of the Committee is February 7, 2017.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 2:25 p.m.		

I. MEMBERSHIP

The Division of Subspecialty Surgery consists of physicians who practice within the medical specialties of Otolaryngology Head and Neck Surgery, Oral Maxillofacial Surgery and Plastic and Reconstructive Surgery. Members may be board certified by the American Board of Otolaryngology Head and Neck Surgery and/or by the American Board of Plastic and Reconstructive Surgery, or by the American Board of Oral and Maxillofacial Surgery. The Division of Subspecialty Surgery also consists of, dental specialists and/or dentists who are either Board Certified or Board Eligible (i.e. successful completion of an ADA accredited residency program) or are able to demonstrate comparable ability, training and experience. The Division will accommodate general dentists and dental specialists who demonstrate comparable ability, training and experience as required for licensure in California.

II. FUNCTIONS OF THE DIVISION

The general functions of the Division of Subspecialty Surgery shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Division and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make regarding recommendations regarding continuing medical education programs pertinent to Division clinical practice;

D. Review and evaluate division member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice;

E. Submit written minutes to the ~~QA/PI~~ Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such action; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital;

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend / Request Focused Professional Practice Evaluation as indicated for (pursuant Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Division rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. DIVISION MEETINGS

The Division of Subspecialty Surgery shall meet at the discretion of the Chief, but at least annually. The Division will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Division members of the Department, but not less than two members, shall constitute a quorum at any meeting.

IV. DIVISION OFFICERS

The Division shall have a Chief who shall be a member of the Active Medical Staff and shall be qualified by training and experience, and demonstrate ability in at least one of the clinical areas covered by the Division.

The Division Chief shall be elected every year by the Active Staff members of the Division who are eligible to vote. If there is a vacancy by the officer for any reason, the Department Chairman shall designate a new Chief, or call a special election. The Chief shall be elected by a simple majority of the members of the Division.

The Division Chief shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from the office, or loses his/her Medical Staff membership or clinical privileges in the Division. Division officers shall be eligible to succeed themselves.

V. DUTIES OF THE DIVISION CHIEF

The Division Chief shall assume the following responsibilities:

A. Be accountable for all professional administrative activities of the Division;
B. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division;
C. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division;
E. Recommend clinical privileges for each member of the Division;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended from the Department of Surgery or the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff ~~Office~~Department;
B. ~~By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated~~;
C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified;
D. Proctoring shall be performed by a member of the Medical Staff at TCMC with the same privileges being proctored.

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~	~~Training~~	~~Six (6) cases~~	~~N/A~~
~~Consult, including via telemedicine (F)~~			
~~Perform history and physical examination, including via~~			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
telemedicine (F)			
Use of energy sources as an adjunct to privileged procedures: Argon, KTP, CO_2	1. Documentation of completion of training for specific energy source(s) to be used; or 2.1. Two (2) cases per energy source requested.	Included in general procedural proctoring	Included in general reappointment volume requirements
Moderate Sedation	See Policy 8710-517	See Policy 8710-517	See Policy 8710-517
Otolaryngology – Head and Neck Privileges			
Basic Otology Category:	1. Successful completion of an ACGME or AOA-accredited residency in otolaryngology 2.1. Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested.	Two (2) cases from this category	Fifty (50) cases reflective of the Basic Otolaryngology privileges requested
All forms of surgery on the auditory canal, the tympanic membrane (i.e. tympanoplasty, ossiculoplasty), and the contents of the middle ear			
Mastoidectomy			
Basic Rhinologic Category:		One (1) case from this category	
Caldwell Luc procedure			
Excision of tumor ethmoid/cribriform			
Fracture repair – nose			
Nasal polypectomy			
Septoplasty, and turbinate surgery			
Basic Head and Neck Category:		Two (2) cases from this category	
Excision of lesions of skin, subcutaneous tissue, mucosa			
Extraction of teeth incidental to tumor resection or repair of traumatic injury			
Fracture repair – mandible, closed			
Harvesting and grafting of alloplasts, bone, cartilage, fascia, fat, nerve, or skin			
Ligation of head and neck vessels			
Local skin flap			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
reconstruction, including harvest			
Parathyroidectomy			
Reduction of facial fractures, closed and isolated open			
Repair of branchial cysts, ducts, fistulas			
Repair of lacrimal system			
Repair soft tissue – lacerations, avulsions, abrasions			
Salivary gland and duct surgery			
Skin/Soft tissue flap, including harvest			
Skin grafting procedures, full thickness or split thickness			
Surgery of the lymphatic tissues of the head and neck			
Thyroidectomy			
Basic Orthognathic Surgery Category:		One (1) case from this category	
• Osteotomy • Grafting • Implantation of the upper and lower jaws for treatment of dentofacial and congenital deformities, and obstructive sleep apnea			
Basic Aerodigestive Tract Category:		One (1) case from this category	
Bronchoscopy/Endoscopy of the airway (larynx, trachea, and bronchial tree) both diagnostic and therapeutic			
Endoscopy of the upper digestive tract (nasopharynx, hypopharynx, esophagus), both diagnostic and therapeutic, including endoscopic treatment of Zenker's			
Lip surgery including lip			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
shave, partial or total resection with primary repair or by local or distant flaps, Cleft lip, and Pedicle lip flap reconstruction			
Surgery on the oral cavity, including soft palate, tongue, mandible, maxilla			
Surgery of the upper aerodigestive tract			
Tonsillectomy, adenoidectomy			
Tracheotomy			
ADVANCED OTOLARYNGOLOGY PRIVILEGES			
Advanced Otology Category:	1. Successful completion of and ACGME or AOA accredited residency in otolaryngology 2.1. Documentation of twenty (20) cases from the previous twenty-four (24) months representative of the privileges requested	One (1) case from this category	Twenty (20) cases reflective of the Advanced Otolaryngology privileges requested
Acoustic Neuroma Surgery			
Surgery of the inner ear and stapes			
Temporal bone resection			
Advanced Rhinologic Category:		One (1) case from this category	
Hypophysectomy			
Orbital exenteration			
Sinus surgery, endoscopic and open			
Advanced Head and Neck Category:		One (1) case from this category	
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction			
Facial nerve repair, grafting, and facial reanimation			
Facial plastic surgery, including blepharoplasty, chemical peel,			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations			
Fracture repair – multiple, open, including LeFort			
Infratemporal fossa/deep parotid lobe tumor excision			
Myocutaneous flap, including harvest			
Neck dissection			
Advanced Aerodigestive Tract Category:		One (1) case from this category	
Composite resection			
Esophageal surgery including diverticulectomy and cervical esophagectomy			
Management of oral sinus cavity and pharyngeal malignancy			
Surgery of the larynx, including biopsy, partial or total laryngectomy, fracture repair			
Tracheal resection			
Special Otolaryngology Privileges:			
Bone anchored hearing aid (BAHA) implant	1. Documentation of completion of training course in bone anchored hearing aid implantation; if training was completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying performance of BAHA procedure. ~~2.~~1. Concomitant mastoidectomy privileges	One (1) case	Concomitant mastoidectomy privileges and one (1) case

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Microvascular flaps and grafts/free tissue and bone transfer, including harvest	1. Successful completion of a training program that included training in microvascular surgery 2.1. Eight (8) cases within the previous 24 months	Two (2) cases	Eight (8) cases
PLASTIC AND RECONSTRUCTIVE SURGERY PRIVILEGES			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Basic Plastic and Reconstructive Surgery Category: Aesthetic (cosmetic) surgery of the head and neck, trunk and extremities: • Abdominoplasty • Contouring (body, facial) • Facial nerve repair, grafting, and facial reanimation • Facial plastic surgery, including blepharoplasty, chemical peel, dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations • Endoscopic cosmetic surgery • Vein injection sclerotherapy	1. Successful completion of an ACGME- or AOA-accredited residency in plastic surgery 2.1. Documentation of one-hundred (100) cases from the previous twenty-four (24) months representative of the privileges requested	Five (5) representative blend of cases	(50) cases reflective of the privileges requested
Breast Surgery: • Augmentation, cosmetic and reconstructive and			

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~implantation~~ • ~~Biopsy~~ • ~~Breast lift (mastopexy)~~ • ~~Congenital anomalies~~ • ~~Mastectomy (subcutaneous and simple)~~ • ~~Reduction~~			
~~Burn management, acute and reconstructive~~			
~~Debridement of wound~~			
~~Harvesting and grafting of alloplasts, bone, cartilage, fat, fascia, nerve, or skin (full or split thickness)~~			
~~Flaps, including harvest:~~ • ~~Local skin flap reconstruction~~ • ~~Myocutaneous flap~~ • ~~Skin/Soft tissue flap~~			
~~Lymph node dissection/lymphadenectomy~~			
~~Repair soft tissue – lacerations, avulsions, abrasions~~			
~~Management of Pathology~~ • ~~Disease limited to oral cavity~~ • ~~Infections of the head and neck region~~ • ~~Management of disease of paranasal sinuses, endoscopic and open techniques~~ • ~~Management of salivary gland disease~~ • ~~Management of oral sinus cavity and pharyngeal malignancy~~			
~~Orthognathic Surgery, includes:~~ • ~~Osteotomy~~ • ~~Grafting~~ • ~~Implantation of the upper and lower jaws~~			

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
for treatment of dentofacial and congenital deformities, and obstructive sleep apnea			
Treatment of skin neoplasms, diseases, and trauma: • Removal of benign and malignant lesions of the skin and soft tissue • Reconstruction by tissue transfer, including grafts and flaps, including harvest • Reconstruction of soft tissue disfigurement/scar revisions			
Hand Surgery Category:		Two (2) cases from this category	
Surgery of hand, extremity, and tendon injuries, acquired and developmental: • Congenital anomalies • Dislocation repair and fusion • Dupuytren's contracture • Hand/wrist fractures • Joint reconstruction with spacers • Nerve transplants • Rheumatoid repair • Synovectomy • Tumors of the bones and soft tissues • Tendon, nerve, ligament, and vessel repair to include Carpal Tunnel Syndrome			
Advanced Plastic and Reconstructive Surgery Category:			
Breast reconstruction utilizing pedicled or microvascular free flaps	1. Successful completion of an ACGME- or AOA-accredited residency in plastic surgery	One (1) case	Five (5) Advanced Plastic and Reconstructive Surgery

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction Reconstruction of congenital and acquired defects of the trunk and genitalia	2.1. Five (5) Advanced Plastic and Reconstructive Surgery procedures during the previous twenty-four (24) months.		procedures
Reconstructive microsurgery: • Microvascular flaps and grafts/free tissue and bone transfer, including harvest • Replantation and revascularization of the upper and lower extremities and digits • Reconstruction of peripheral nerve injuries	1. Successful completion of a training program that included training in microvascular surgery 2.1. Eight (8) cases within the previous 24 months	Two (2) cases	Eight (8) cases

GENERAL DENTISTRY

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
Dental implantation General restorative dentistry Simple exodontia Periodontal therapy Surgery of Alveolar structures and lower jaw	1. DDS or DMD 2.1. Twenty (20) cases within previous 24 months	One (1) case for this category, or proctoring considered complete when released from proctoring for Oral and Maxillofacial Surgery category.	Twenty (20) cases
Local and regional anesthesia	1. General Anesthesia Permit 2.1. Evidence of (10) cases of regional anesthesia administration within the previous 24 months		

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
ORAL AND MAXILLOFACIAL SURGERY			
Trauma Surgery limited to: • Midface and upper jaw • Multiple trauma to face, including nasoethmoid, orbital and zygoma fractures • Airway management, including cricothyroidotomy and tracheotomy	1. DDS or DMD 2. Successful completion of a training program in Oral and Maxillofacial Surgery 3.1. One-hundred (100) Oral and Maxillofacial Surgery cases reflective of the scope of privileges requested within the previous 24 months.	One (1) case	Fifty (50) cases reflective of the scope of privileges requested
Management of Pathology • Disease limited to oral cavity • Infections of the head and neck region • Management of disease of paranasal sinuses, endoscopic and open techniques • Management of salivary gland disease • Management of head and neck malignancy		Two (2) cases	
Reconstructive Surgery • Dental implantology • Facial nerve repair, grafting, and facial reanimation • Reconstructive procedures limited to oral cavity and oropharynx • Reconstructive procedures of facial structures		One (1) case	

Privileges	Initial Appointment	Proctoring	Reappointment (every 2 years)
• Harvesting tissues from distant site, i.e. iliac crest, rib, soft tissue flaps			
Orthognathic Surgery, includes: • Osteotomy • Grafting • Implantation of the upper and lower jaws for treatment of dentofacial and congenital deformities, and obstructive sleep apnea		One (1) case	
TMJ Surgery • Endoscopy • Joint implantation and replacement		One (1) case	
Cleft/Craniofacial Surgery • Correction of primary cleft lip and palate • Correction of residual deformities, fistulae • Correction of palatal incompetence • Craniofacial reconstruction		One (1) case	
Facial plastic surgery, including blepharoplasty, chemical peel, dermabrasion, liposuction, mentoplasty, otoplasty, rhinoplasty, rhytidectomy, and implantation of autogenous and homologous grafts, and allografts, and repair of lacerations	1. Permit to 'perform elective facial cosmetic surgery' from the Dental Board of California 2.1. Ten (10) representative blend of cases within the previous 24 months	Two (2) cases	Ten (10) cases
Minor Procedures Forensic Outpatient Clinic			
Anterior Nasal Packing (F)	As required for general specialty	Proctoring complete when released from specialty	N/A
Collection of Specimens:			

~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Nasopharyngeal, throat, and wound (F)~~	~~specific privileges~~	~~specific proctoring~~	
~~Nasopharyngeal Endoscopic Procedures (F)~~			
~~Removal of Impacted Cerumen (F)~~			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

~~VII.~~ VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor with current unrestricted privileges as indicated until his or her privilege status is established by a recommendation from the Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors;

B. All Active members of the Division will act as proctors. ~~An associate~~One or all of the member's associates may monitor up to 50% of the required proctoring. Additional cases may be proctored as recommended by the Division Chief. It is the responsibility of the Division Chief to inform the monitored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care;

C. Supervision of the member by the proctor will include concurrent for invasive cases or retrospective chart review for non-invasive privileges of cognitive processes and direct observation of procedural techniques. The monitor must be present in the operating room for a sufficient period of time to assure himself/herself of the member's competence~~, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE SURGEON'S COMPETENCE~~;

D. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled);

E. The member shall have free choice of suitable consultants and assistants. The proctor may assist the surgeon;

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports;

G. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified); Blank forms will be available at the front desk in the O.R. or at the Medical Staff Department and provided to the proctor for completion~~from the Operating Room Supervisor and/or the Medical Staff Office~~.

H. Forms will be made available to the member scheduling the case for surgery and immediately forwarded to the proctor for completion. It is the responsibility of the new member to notify the Operating Room ~~Supervisor~~ personnel of the proctor for each case;

I. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.

~~VIII.~~ IX. EMERGENCY DEPARTMENT CALL

Active Medical Staff Division members may participate in the Emergency Department Call Roster subject to the mandatory Medical Staff Bylaws requirement (Section 3.2-2) as needed or consultation panel as determined by the Medical Staff. Please refer to Medical Staff Policy and Procedure 8710-520.

Consulting and Provisional staff members may participate in the Emergency Department Call Roster at the discretion of the Chief of the Division. The care provided by an on-call physician will not create an obligation to provide further care.

APPROVALS:

Division of Subspecialty Surgery:	07/01/2015
Department of Surgery:	07/01/2015
Medical Executive Committee:	07/22/2015
Governance Committee:	08/04/2015
Board of Directors:	08/27/2015

TRI-CITY HEALTHCARE DISTRICT

GOVERNANCE AND LEGISLATIVE

COMMITTEE CHARTER

The Governance and Legislative Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to monitor developments in governance best practices, make recommendations to the District's Board of Directors ("Board") on governance matters referred to it, and monitor, report upon, and make recommendations to the Board regarding state and federal legislative developments related to District and hospital governance, legislative affairs and advocacy.

1. **Governance Policies and Procedures**: The Committee shall respond to Board requests, monitor developments in, report upon and make recommendations to the Board regarding:

    a. Changes in best practices and legal requirements relating to healthcare district governance and healthcare reform initiatives;

    b. The District's governing documents, including Bylaws, Policies, Committee charters, and other governance or policy matters as requested by the Board;

    c. Proposed amendments to the Medical Staff Rules and Regulations and Privilege Cards. Amendments to Medical Staff Bylaws will be pursuant to the attached Pathway for Medical Staff Bylaw Amendments;

    d. Review its Charter every three years or as necessary;

    e. Develop and maintain an annual work plan, as may be amended from time-to-time by the Committee Chair;

2. **Legislative Affairs Oversight:** The Committee shall monitor, report upon and make recommendations to the Board regarding:

    a. Significant changes to state and federal laws, rules and regulations and accreditation standards applicable to the District, with special attention to the legislative and policy agendas of associations of which the District is a member (e.g., Association of California Healthcare Districts and California Hospital Association);

    b. Actions to be taken to address or implement legislative or regulatory changes proposed, pending or enacted, including advocacy efforts.

II. Membership

The Committee shall consist of three Directors, a minimum of three (3) but no more than four (4) community members, and three physicians. In addition, The CEO, COO, Manager, Medical Staff Services, and Chief Compliance Officer shall support the Committee without vote, but may be counted toward a quorum as alternatives in the event absences result in the Committee lacking a quorum.

Each Committee member shall have a basic understanding of governance and legislative affairs of public hospitals, and should have experience and familiarity with the specialized issues relating to governance of complex healthcare organizations, healthcare laws and legislative affairs.

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for review and approval of recommendations at its meetings. The Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas, and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all recommendations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved October 27, 2011 by Board of Directors
Approved August 30, 2012 by Board of Directors
Approved March 28, 2013 by Board of Directors
Approved May 29, 2014 by Board of Directors

TRI-CITY HEALTHCARE DISTRICT

FINANCE, OPERATIONS AND PLANNING

COMMITTEE CHARTER

The Finance, Operations and Planning Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide governance oversight and to make recommendations to the District's Board of Directors (the "Board") by overseeing the functions of the District directly related to Finance, Operations, and Planning. The Committee focuses on matters that are material to the District's operations. "Material" generally means financial impacts exceeding the Chief Executive Officer's approval limit as well as matters that, due to their nature, could expose the District to significant risks.

1. **Finance Oversight**: The Committee will oversee the Finance function of the District, including the following:

   a. Review monthly financial statements prepared by the Finance Department and presented by the Chief Financial Officer;

   b. Monitor the monthly financial statements for unusual trends and have the Chief Financial Officer provide a detailed explanation of the variances;

   c. Report to the Board regarding any issue involving the integrity or trustworthiness of the District's financial statements;

   d. Review any proposed changes to Finance-related policies and procedures, including Board Policy No. 14-017 (investments) and 15-013 (procurement).

2. **Operations Oversight:** The Committee shall:

   a. Review monthly report of operations metrics for departments noted on the Committee Work Plan;

   b. Review significant new services to be provided by the District and add to Committee Work Plan;

   c. New contracts (not within the scope of another Board committee) as well as amendments and renewals of existing contracts that exceed the approval authority of the Chief Executive Officer as outlined in Administrative Policy and Procedure #232, Board Policy No. 15-013 and state law.

3. **Planning Oversight:** The Committee shall perform initial screening and analysis for potential recommendation for advancement to the Board for consideration of the following:

   a. Proposed real estate transactions;

   b. Proposed acquisitions, and contractual joint ventures;

   c. Physician recruitments and other contracts with physicians;

   d. Procurements requiring approval by the Board under Administrative Policy and Procedure #232, Board Policy No. 15-013, or state law;

   e. Material matters related to the integration between the District and independent physicians and physician groups.

II. Membership

The Committee shall consist of three Directors, five community members, and three physicians.

Each community committee member shall have a basic understanding of finance and accounting, and should have experience and familiarity with the specialized issues relating to healthcare finance. At least one community member of the Committee shall have accounting or related financial management expertise, as evidenced by the certified public accountant designation or other education and/or work-related credentials.

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all recommendations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the full Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved: 9/20/2011 by Board of Directors
Approved: 3/28/2013 by Board of Directors
Approved: 5/29/2014 by Board of Directors

TRI-CITY HEALTHCARE DISTRICT

EMPLOYEE FIDUCIARY RETIREMENT PLAN SUBCOMMITTEE CHARTER

The Employee Fiduciary Retirement Plan Subcommittee (the "Subcommittee") of the Human Resources Committee has multiple purposes and is delegated certain key responsibilities, per Government Code §§ 53216.5 and 53216.6, to act with the care, skill, prudence, and diligence under the circumstances that a prudent person acting in a like capacity and familiar with these matters would use in the conduct of an enterprise of a like character and with like aims.

I. Purposes

The Subcommittee is to provide assistance to the Board of Directors in its governance oversight duties and to make recommendations to the Tri-City Healthcare District ("District") Board of Directors ("Board") in matters regarding the employee retirement plans offered by the District (the "Plans"). The Subcommittee is delegated the authority to prudently select and monitor the performance of an ERISA section 3(38) investment manager, as if ERISA applied to the Plans, as well as a vendor to provide recordkeeping services for the Plans. The Plans' investment manager shall make decisions regarding investment options offered to plan participants through the Plan, and shall perform as a fiduciary under ERISA, as though it applied to the Plans. While the District recognizes that the Plans are not subject to the Employee Retirement Income Security Act ("ERISA"), the Plans should conform to ERISA principles in order to comport with best practices with respect to employee retirement plans.

II. Membership

The Subcommittee shall be comprised of representatives from the Human Resources Committee and may include members of the community, as selected by the Board.

III. Meetings

It is anticipated that the Subcommittee will meet at least quarterly, although the Subcommittee may meet more or less frequently as needed. The Subcommittee may establish its own meeting schedule annually.

IV. Minutes

The Subcommittee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

Although the Subcommittee is a subcommittee of the Human Resources Committee, the Subcommittee will report directly to the Board regarding all determinations made or actions

taken pursuant to the Subcommittee's duties and responsibilities, and will provide updates to the Board on at least a quarterly basis. The Subcommittee shall also report its actions and recommendations to the Human Resources Committee as a matter of course, but the Committee as a whole shall have no power to change or alter the recommendations of the Subcommittee. The Subcommittee's determinations shall be final as to matters as to which it has been delegated fiduciary responsibility.

VI. The Subcommittee shall review its Charter every three years.

VII. Conduct

Each Subcommittee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee. In addition, members of this Committee are designated as public officials under the Conflict of Interest Code of the District.

Approved by BOD: 9/29/11
Approved by BOD: 5/30/13
Approved by BOD: 5/29/14

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #14-009

POLICY TITLE: Requests for Information or Assistance by Board Members

1. Requests for information or assistance by individual Directors requiring more than 15 minutes of staff time shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. All questions regarding confidentiality and privilege shall be directed to the General Counsel, Compliance Officer or their designees. All requests shall be stated clearly and shall be specific. In making requests, Directors shall keep in mind that District staff time and resources are both limited and expensive, and that staff members have other duties.

2. All requests for information which concern another Director shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. A copy of the written request shall be directed to all members of the Board including the member concerning whom information is requested, along with any information provided in response to the request.

3. All requests for information relating to Closed Session materials, including requested inspection, shall be directed to the Chairperson of the Board, with a copy to the President/CEO or his/her designee and shall be subject to the confidentiality provisions of Policy #022.

4. Requests for information and assistance shall receive a response as soon as reasonably possible, although not necessarily immediately. The President/CEO shall have the final authority to determine by what means and when District staff responds to the request. If, in the judgment of the Chairperson of the Board or the President/CEO, the request requires a material amount of employee time or the request includes information or documents which are confidential or privileged or the request is one which is deemed appropriate for Board consideration, the President/CEO or Chairperson may ask for a decision from the full Board of Directors before action is taken.

5. Should any Director's request for information or analysis require more than 30 minutes of staff time, the Chairperson or the CEO may require the Director to secure Board approval for the work.

6. This Policy shall not preclude the Chairperson from exercising authority granted under District Bylaws or Board Policy: Role and Powers of Chairperson. Nothing in this policy shall be construed to limit the rights of a Director under the Public Records Act.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	It was moved by Director Mitchell to recommend approval of the Employee Fiduciary Subcommittee Charter as presented and direct the Human Resources Committee to consider appointing Director Grass to the Employee Fiduciary Subcommittee. Director Reno seconded the motion. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve the Employee Fiduciary Subcommittee Charter as presented; item to be placed on Board Agenda and appear in agenda packet. Direct Human Resources Committee to consider appointment of Director Grass to the Employee Fiduciary Subcommittee; item to be placed on next Human Resource Committee agenda.	Ms. Donnellan Ms. Donnellan
c. Review and discussion of Board Policy 14-009 – Requests for Information or Assistance by Board Members	Director Reno stated Board Policy 14-009 – Requests for Information or Assistance by Board Members was placed on today's agenda to discuss how information is communicated as a result of a Director's request for information. Mr. Moser explained the policy specifically addresses requests for information by Board members in various circumstances and who those requests should be directed to. Mr. Dietlin stated the policy is essential for voluminous requests that require a significant amount of staff time to compile. Following further discussion the committee concurred the policy addresses these concerns as written and did not recommend any additional changes. **It was moved by Director Reno to recommend approval of Policy 14-009 – Requests for Information or Assistance by Board Members as written. Director Mitchell seconded the motion. The motion passed unanimously.**	Recommendation to be sent to the Board of Directors to approve Board Policy 14-009 – Requests for Information or Assistance by Board Members as written; item to be placed on Board Agenda and appear in agenda packet.	Ms. Donnellan
d. Review and discussion of Board Policy 16-044 – Distribution of Tickets and Passes to District Sponsored or Controlled Events and Donated Tickets and Passes	Board Policy 16-044 – Distribution of Tickets and Passes to District Sponsored or Controlled Events and Donated Tickets and Passes was pulled from the agenda.	None.	

Tri-City Medical Center
Audit, Compliance & Ethics Committee
January 19, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino, DPT, PT; Director Leigh Anne Grass; Jack Cumming, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Dr. Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Kapua Conley, COO; Cheryle Bernard-Shaw, CCO
Others Present:	Diane Racicot, General Counsel; Teri Donnellan, Executive Assistant
Absent:	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairperson Schallock.		
2. Approval of Agenda	**It was moved by Director Dagostino and seconded by Mr. Leslie Schwartz to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	Ms. Donnellan
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Introductions	Committee members introduced themselves and provided a brief summary of their background and experience.	Information only.	
5. Compliance Overview Update	Ms. Cheryle Bernard-Shaw, CCO gave a comprehensive overview of the Compliance Program Plan for FY2015-2017. Ms. Bernard-Shaw stated her charge was to focus on physician contract compliance and ensure that the Compliance Program that was essentially initiated on paper was put into effect. She stated the majority of items listed	Information only.	

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	on the plan have been completed and she will draft a new plan for FY2017-2019. *Ms. Kathy Topp joined the meeting at 9:00 a.m.*		
6. Audit/Finance Overview Update	Mr. Ray Rivas provided a review of the audit process. He explained Moss Adams performed the FY2016 Financial Statement Audit and tested internal controls over patient charges, billings, cash collections, and write offs of accounts, etc. Mr. Rivas stated prior to the main field work the Auditors will come to the Audit Committee to report any changes to the regulations and describe their Scope of Services and areas of audit emphasis as well as the audit timeline. In August, the auditors will begin their field work and will present their findings to the Audit Committee and discuss the opinion they plan to issue. The Audit Committee, after hearing the audit presentation will then make a recommendation to the Board to accept the audit as presented. Chairman Schallock pointed out that this past year the Audit Committee had discussion as to whether to go out to bid to other audit firms or continue with Moss Adams. At that time the committee recommended Moss Adams be engaged to perform the Financial Statement Audit with a partner rotation. Mr. Dietlin stated it is best practice to rotate auditing partners to get a fresh set of eyes on the books. With regard to financial presentations, Mr. Rivas stated the financials are presented on a quarterly basis. At the February meeting he plans to present the December.	Information only.	
7. Ratification of minutes – November 17, 2016	**It was moved by Mr. Leslie Schwartz and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed with Directors Dagostino and Grass abstaining from the vote.**	Minutes ratified.	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
5. Old Business a. Community Member Opening	Chairman Schallock reported we have one vacancy on the committee and will be conducting interviews at the February meeting to fill that vacancy.		
6. New Business			
A) Administrative Policies & Procedures: 1) 8610-561 – Responding to Compliance Issues – Reports of Suspected misconduct Investigation	Ms. Kathy Topp, Director of Education and Clinical Informatics explained a redlined copy of Policy 8610-561 was distributed to committee members today to reflect changes that were made to the policy. Ms. Bernard-Shaw stated when there is an investigation that involves the Executive Team, we want to assure the Board that they receive that information in timely manner, particularly if it involves the CEO or CCO. She explained revisions that have been proposed to the policy ensure that process is easy to implement. General Counsel, Ms. Racicot stated in October of 2016, the Committee had extensive discussion on this policy and it was sent back for further revisions. The policy presented today memorializes those discussions and address concerns raised by committee members. In response to a question raised by Director Grass, Ms. Bernard-Shaw explained what checks and balances are in place. Ms. Racicot stated Ms. Bernard-Shaw, in her role as Chief Compliance Office, must have some discretion to determine reports that may be closed and that she has a process in place to make those judgments and ultimately she reports to the Board. Mr. Cumming questioned if there is a central document that contains the definitions of certain terms used in the policies. Ms. Topp stated there is not a central document however, when deemed necessary, definitions are contained in the individual policies. Minor revisions were recommended by committee members for clarity.		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	It was moved by Mr. Cumming to recommend approval of Compliance Policy 8610-561 with revisions as described. Director Dagostino seconded the motion. The motion passed unanimously.	Recommendation to be sent to the Board of Directors to approve Policy 8610-561 with revisions as described; item to appear on Board Agenda and contained in Board Agenda packet.	Ms. Donnellan
B) FY2017 Financial Statement Audit	The committee had extensive discussion regarding the process of selecting an auditor for the FY 2017 Financial Statement Audit. Committee members gave their impressions of the Audit Team that was utilized in the FY2016 audit. Director Grass expressed concern that some liabilities were not listed on the FY2016 audit. **After further discussion, it was moved by Ms. Kathryn Fitzwilliam to direct management to seek an engagement proposal from Moss Adams to perform the FY2017 Financial Statement Audit. Mr. Leslie Schwartz seconded the motion. The motion passed with Director Grass voting no.**	Recommendation to direct management to seek an engagement proposal from Moss Adams to perform the Fy2017 Financial Statement Audit; item to appear on Board agenda.	Ms. Donnellan
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Schallock made an oral announcement of the items listed on the agenda to be discussed during closed session which included approval of closed session minutes and two matters of Potential Litigation.		
8. Motion to go Into closed session	**It was moved by Director Dagostino and seconded by Mr. Jack Cumming to go into closed session at 9:51 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 10:23 a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code,	Chairperson Schallock reported no action was taken in closed session.		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
Section 54957.1)			
11. Comments from Committee Members	None.		
12. Date of Next Meeting	Chairperson Schallock stated the Committee's next meeting will be held on February 16, 2017.	**The committee's next meeting is scheduled for February 16, 2017.**	
13. Adjournment	Chairperson Schallock adjourned the meeting at 10:24 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
January 19th, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Responding to Compliance Issues - Reports of Suspected Misconduct Investigation	561	3 year review, practice change	Forward to BOD for approval with revisions

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 05/12

SUBJECT: Responding to Reports of Suspected ~~or~~ Non-Compliance and Misconduct

REVISION DATE(S):

POLICY NUMBER: 8750-561

Department Approval Date(s):	01/16
Administrative Policies and Procedures Approval Date(s):	08/16
Organizational Compliance Committee Approval Date(s):	08/16
Medical Executive Committee Approval Date(s):	09/16
Audit and Compliance Committee Approval Date(s):	01/17
Board of Directors Approval Date(s):	05/12

A. **PURPOSE:**

1. To identify Tri-City Healthcare District (TCHD)'s policy regarding its response to reports of suspected non-compliance and misconduct including the investigation of such reports.

B. **POLICIES**:

1. The Chief Compliance Officer (CCO) and/or his or her designee is responsible for conducting and overseeing investigations of reports of potential or actual non-compliance with ethical standards, applicable laws and regulations and TCHD's Code of Conduct and policies and procedures.
2. The CCO is responsible for reporting the outcome of investigations to Executive Management, Directors and appropriate staff in a timely manner.
3. Reports involving allegations of non-compliance or misconduct by individuals or entities who are hired by the Board (CEO, CCO, General Counsel, Board consultants) shall be reported immediately to the Board.

C. **PROCEDURES**:

1. Upon receipt of a report of suspected or actual non-compliance or misconduct, a Confidential Reporting Line (Values Line) report, audit findings or other information suggesting a possible compliance issue, the Chief Compliance Officer (CCO) will record the information (as detailed below) and develop a preliminary written plan of action, usually within 72 hours of receiving the report unless the reported matter requires ~~urgent~~**immediate** attention.
2. If the CCO makes an initial assessment that the matter does not involve a bona fide instance of non-compliance or misconduct and that it warrants no further action, the CCO will close the report documenting this determination.
3. If the CCO determines after initial assessment that the matter does not involve a bona fide instance of non-compliance or misconduct but raises an area for improvement or concern for future violations, the matter will be referred to the appropriate staff or committee for further action.
4. If the CCO determines after initial assessment that the matter does raise a bona fide concern of suspected non-compliance or misconduct, If the CCO shall promptly and thoroughly investigate and oversee the investigation of such matter. The CCO may also, on his/her own initiative, investigate instances of suspected non-compliance or misconduct that have not been reported but are identified through other sources such as audit findings.
5. The scope of the investigation/review will be determined by the Chief Compliance Officer or his or her designee; however, investigations/reviews will be conducted in a thorough manner. For example, the veracity of individual statements provided in an interview may be verified by documentary evidence or corroborating evidence.

6. Depending on the nature and severity of the suspected non-compliance or misconduct the Chief Compliance Officer may consult with appropriate TCHD Departments for additional information.
7. The CCO may also consult with and utilize outside legal counsel to assist in conducting certain internal investigations or in providing legal guidance and support for CCO investigations.
8. In conducting an internal investigation, the CCO, his or her designee and other investigators engaged by the CCO shall as necessary and appropriate:
   a. Take steps to secure, and prevent the destruction of, documents and other evidence relevant to the investigation.
   b. Review relevant documents and data.
   c. Interview persons with relevant information.
   d. Take all reasonable and necessary steps to ensure that identified actual misconduct or non-compliance is stopped and does not recur.
   e. Where the investigation reveals actual coding, billing and/or documentation issues, take all reasonable and necessary steps to ensure that TCHD does not submit non-compliant claims during the pendency of the investigation.
9. Internal investigations may encompass the following components: identification of non-compliant conduct, analysis of the root cause of identified non-compliant conduct, detection of gaps and weaknesses (e.g. function, systems, supervision, education and training, etc.) and recommendations for, and oversight of, corrective and remediation actions.
10. Internal reviews and investigations will be conducted in a fair and objective manner. Individuals involved in the underlying conduct which is the subject of the investigation or review will not direct the investigation.
11. Investigations will be conducted uniformly to the extent possible.
12. The investigation will be conducted and concluded within time periods that are reasonable based on the allegations under investigation and in order to comply with Federal and State fraud and abuse reporting and/or overpayment laws where such matters are at issue.
13. If applicable, the CCO will review whether any implemented "litigation hold" needs to be released before closing the investigation.

D. **DOCUMENTATION:**

1. Upon conclusion of the investigation a short, written report will be prepared by the Chief Compliance Officer or his or her designee or other party approved to conduct the investigation which will generally include:
   a. A description of the allegation(s)
   b. A description of the nature of the suspected matter investigated (if different than the allegation(s))
   c. The investigation procedures
   d. Identification of the persons involved and their role in the conduct (consistent with policy 8750-559; Reports of Suspected Misconduct: Confidentiality)
   e. Conclusions related to whether the suspected allegations are unfounded or founded
   f. Description of corrective actions/remediation and
   g. Where applicable, an estimate of the nature and extent of liability or overpayment due.
2. TCHD shall maintain in a confidential and secure fashion, copies of any work papers, interview notes and any other documents generated as part of the internal investigation.
3. TCHD shall maintain in the Compliance Program files copies of any key documents that relate to the practice or matter under investigation.
4. TCHD shall document the scope, findings and recommendations of the internal investigation and shall maintain such documentation in the Compliance Program files.
5. In connection with any internal investigation, TCHD shall maintain in a confidential and secure fashion any documents, whether electronic or hard copy, that are attorney-client communications or attorney work-product. Such documents should be appropriately labeled or stamped as attorney-client privileged or attorney work product and maintained consistent with District's document retention policies. However, failure to label such documents in this manner will not mean the documents are not protected under the attorney-client privilege or attorney work product doctrine.

E. **REPORTING**:

1. The CCO will report the outcome of investigations to Executive Management, the Board of Directors and other staff (if and as appropriate) in a timely manner. Reporting mechanisms will vary and will be determined by the CCO.
2. The CCO will review whether the investigation results must be reported to any regulator and the mechanism for doing so. The CCO will confer with Executive ~~Staff~~ **Management** and the Board as appropriate before submitting such reports.
3. The CCO will notify the CEO, Board of Directors and General Counsel immediately if any report or subsequent investigation suggests that the conduct at issue raises criminal ramifications.

F. **CONFIDENTIALITY**:

1. The existence and substance of the investigation or review will be kept confidential to the extent possible and as appropriate under the circumstances and applicable laws and regulations.

G. **REFERENCES:**

1. Administrative Policy 8750-559; Reports of Suspected Misconduct: Confidentiality
2. Administrative Policy 8610 - 424; Coaching and Counseling for Work Performance

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

December 8, 2016 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on December 8, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry Schallock

Also present were:

Greg Moser, General Legal Counsel
Jody Root, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Ray Rivas, Acting Chief Financial Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Kellett to approve the agenda. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the December 8, 2016 Regular Board of Directors Meeting Agenda.

4. Oral Announcement of Items to be discussed during Closed Session.

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser made an oral announcement of the items listed on the December 8, 2016 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; one Report Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding four (4) matters of Existing Litigation; one (1) matter of Potential Litigation, Discussion of cybersecurity issues for electronic portal systems, Public Employee Evaluation: General Counsel and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Schallock to go into closed session at 1:31 p.m. The motion passed unanimously (7-0).

Mr. Moser briefly reviewed closed session rules. He stated closed session material is often considered attorney client privileged and always confidential under the Brown Act. Further, the Board can impose civil penalties and bar a Board Member from closed session for disclosing information heard in closed session.

6. The Board adjourned to Closed Session at 1:40 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in open session.

10. Director Dagostino led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12. Introduction and welcome of new Board Member Leigh Anne Grass

Chairman Dagostino introduced and welcomed the newest member to the Board, Leigh Anne Grass.

13. Special Award Presentation

a) Honoring Ramona Finnila for her service on the TCHD Board of Directors

Chairman Dagostino displayed a plaque to recognize former Director Ramona Finnila for her dedication and service on the Board.

14. Special Presentation

a) Pulmonary Rehab

Ms. Sharon introduced Ms. Amy Waldrop, Manager for Pulmonary Rehab & Respiratory Services.

Ms. Waldrop highlighted the Pulmonary Harmonica Program which provides lung exercise therapy to the Pulmonary Rehab patients. She explained the Harmonica Program was introduced in June by our Pulmonary Rehab Coordinator, Ms. Heather Longwell and was funded by our Foundation. Ms. Waldrop showed a news clip from *Channel 8 News* filming our patients in action with the harmonicas.

Director Reno questioned what the enrollment is in the Pulmonary Rehab program. Ms. Longwell stated enrollment ranges from approximately 20-24 patients and therapy is administered two times per day, twice per week.

Ms. Schultz commented that the gentleman who addressed the Board last month told her he has been to two other major Pulmonary Rehab Centers in San Diego and Tri-City has the best!

15. Community Update–

(1) Palliative Care update – Dr. Loren Novak

Ms. Sharon Schultz, CNE introduced Dr. Loren Novak, one of our primary care physicians and Medical Director for our Supportive Care and Palliative Care program. Ms. Schultz stated Dr. Novak was instrumental in getting the program up and running as he is Board Certified in Palliative Care.

Dr. Novak provided a brief summary of his background and experience, noting he has been on staff at Tri-City for over 18 years. He stated the Supportive Care & Palliative Care program is a collaborative effort between Tri-City Medical Center, Tri-City Home Health, Silverado Supportive Care and Hospice and San Luis Rey Medical Group. He stated the program was launched a little over four months ago and provides a full complement of palliative services for patients in the hospital diagnosed with multiple chronic illnesses as well as extending out into the community with our partner Tri-City

Home Health. Dr. Novak provided a detailed explanation of the program which provides assistance to the ER physicians, hospitalists and intensivists in providing family meetings; assist in keeping the patient stable in the home, thus reducing any unnecessary ER visits.

Director Reno stated she recently had two major surgeries and expressed her appreciation to Ms. Susan Platt, her Palliative Care Nurse. She stated "Susan deserves a gold medal."

Board members expressed their appreciation to Dr. Novak and his team for their wonderful work.

No action was taken.

(2) ED Throughout Presentation – Dr. Cary Mells

Ms. Sharon Schultz, CNE introduced Dr. Cary Mells, Chairman of the Emergency Department.

Dr. Mells commented on Dr. Novak's presentation stating the Palliative Care program is a big help with Emergency Department patients.

Dr. Mells provided a presentation on Process Improvement Initiatives that have been designed and put in place over the last few months to decrease door to provider time, decrease LWBS, decrease LOS and improve patient satisfaction.

Dr. Mells stated the "zoomer nurse" performs specific tasks that the Emergency Department needs to be done and trials have reflected a decrease in LOS.

Dr. Mells presented a series of graphs reflecting LOS for all Emergency Department patients. He stated the graph he is most proud of is LWBS, which indicates a significant downward trend.

Dr. Mells reviewed future plans for 2017 including Triage Re-Design plans which have been approved by OSHPD.

Director Grass commended Dr. Mells and his team on their efforts. She stated the impact made is significant.

Chairman Dagostino, along with fellow Board members also reiterated Director Grass's comments.

No action was taken.

16. Report from TCHD Auxiliary, Pat Morocco, President

Mr. Pat Morocco, TCHD Auxiliary President stated in addition to volunteer hours, the Auxiliary also makes money. Mr. Morocco presented a check on behalf of the Auxiliary to the hospital and the Rehab Department in the amount of $70,167.98.

Ms. Schultz introduced Ms. Priya Joshi, Director of Rehab Services. Ms. Joshi expressed her appreciation for the donation by the Auxiliary and commented that

their donation made it possible for a patient who was here for 11 months stand up and walk for the first time.

Ms. Joshi and her team presented a plaque to the Auxiliary in appreciation for their generosity.

No action was taken.

17. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer for the Foundation reported the Diamond Ball was wildly successful, grossing $750,000 which is substantially higher than prior years. Mr. Newhart presented a video of the event to relive the magic. Mr. Newhart recognized co-chairs of the Diamond Ball Gayle and Dr. David Tweedy, Kevin and Ellen Stotmeister, Jennifer and Dr. Warren Paroly as well as Foundation staff Rosella Saucier and Danielle Porter.

Mr. Newhart stated the next upcoming event for the Foundation is Havana Nights Casino Night which will be held on May 20th at the Sheraton Carlsbad.

18. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO commented on the outstanding reports that were just presented. He stated it bears repeating that Tri-City Hospital is owned, managed and governed and by this community. The Mission is to advance the health and wellness of the community we serve which is evidenced by the reports from Pulmonary Rehab, the Emergency Department, Palliative Care, the Auxiliary and the Foundation. Mr. Dietlin commented on how fortunate we are to have such an engaged and supportive community.

Mr. Dietlin invited Ms. Sharon Schultz, CNE and Ms. Alexandra Magnano from Life Sharing to come forward to discuss the most precious gift of all, the gift of life.

Ms. Schultz stated Ms. Magnano is our liaison from Life Sharing and she is here today to share some very good news with us.

Ms. Magnano explained Life Sharing is the organ procurement organization that is federally designated to serve San Diego & Imperial County. She stated Life Sharing has worked with Tri City for many years and has a wonderful partnership with us. Ms. Magnano stated this year alone Tri-City has saved 14 lives through the organ procurement program. She commended the nurses and staff who have worked with Life Sharing on these cases. In addition, Tri City has a 100% overall conversion rate which is the top conversion rate in the entire county and a great accomplishment.

Ms. Magnano stated community outreach and education is very important with not only staff but with patients and their families and Tri-City has been awarded the Platinum level from the HRSA Workplace Partnership for Life Campaign for our participation.

Ms. Schultz recognized some of the nurses who have worked with Life Sharing to give life back to individuals in the community.

Mr. Dietlin reiterated Ms. Schultz's comments. He also commented that the ornaments on the tree in the lobby recognized those individuals who have donated organs to save a life.

No action was taken.

19. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date as follows (Dollars in Thousands):

- Operating Revenue – $111,655
- Operating Expense – $111,154
- EBITDA- $7,459
- EROE - $2,364

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 184
- Adjusted Patient Days – 38,876
- Surgery Cases – 2,094
- Deliveries – 966
- ED Visits – 21,804

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $28,053
- Operating Expense – $27,532
- EBITDA - $2,365
- EROE - $1,118

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 184
- Adjusted Patient Days – 9,805
- Surgery Cases – 517
- Deliveries – 230
- ED Visits – 5,318

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.1
- Days in Net Accounts Receivable – 50.3

Mr. Rivas presented graphs which reflected trends in Net Days in Patient Accounts Receivable, Average Daily Census excluding Newborns, Adjusted Patient Days, and Emergency Department Visits.

In response to a question raised by Director Reno, Mr. Rivas explained when a figure is preceded by a "minus", that indicated an unfavorable variance to budget.

No action was taken.

20. New Business

a. Consideration and possible action to elect Board of Director Officers for calendar year 2017.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors nominate the following slate of officers for 2017:

- **Chairman – Director Dagostino**
- **Vice Chair – Director Kellett**
- **Secretary – Director Mitchell**
- **Treasurer – Director Grass**
- **Assistant Secretary – Director Nygaard**
- **Assistant Treasurer – Director Reno**
- **Board Member – Director Schallock**

General Counsel, Mr. Moser confirmed a second is not required to the motion.

Hearing no other nominations, Chairman Dagostino called for the vote.

The vote on the Motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration to approve Resolution No. 780, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Issuance, Execution and Delivery of Replacement Term notes and Related Documents under Amended Credit Agreement and Certain Other Actions Related Thereto.

Mr. Rivas explained this motion is to extend our current loan of $51 million with Bank of the West. He stated we anticipate refinancing the $51 million through a loan with HUD or other lenders and this extension will carry us over pending funding of that loan. Mr. Rivas noted Bank of the West is willing to extend this lease without any prepayment penalty.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve Resolution 780, A Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Issuance, Execution and Delivery of Replacement Term Notes and Related Documents under the Amended Credit Agreement and Certain Other Actions Related Thereto. Director Nygaard seconded the motion.

Director Reno stated she found the Resolution convoluted and confusing.

Mr. Rivas explained under District policy we were not allowed to enter into this agreement for longer than a district year at a time which is approximately 13 months and that is why the loan has been rolled over from time to time.

Mr. Rivas reiterated that the fact that Bank of the West has waived the pre penalty is extremely favorable.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**Grass, Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Consideration to appoint Mr. Wayne Lingenfelter to an additional two-year term on the Finance, Operations & Planning Committee.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors appoint Mr. Wayne Lingenfelter to an additional two-year term on the Finance, Operations & Planning Committee as recommended by the committee. Director Schallock seconded the motion.

Mr. Lingenfelter expressed his appreciation for the opportunity to serve an additional two-years on the committee.

Mr. Lingenfelter commented that the Directors of Departments and Nursing have done an outstanding job of managing labor which is reflected by the reduction of expenses by $5 million.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

d. Approval of Physician Recruitment Agreement with Dr. Anton M. Kushnaryov and North County Ear, Nose, Throat, Head and Neck Surgery

It was moved that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment Agreement with Dr. Anton M. Kushnaryov and North County Ear, Nose, Throat and Head & Neck Surgery not to exceed $35,000 in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District as approved by the Finance, Operations & Planning Committee and subject to legal review of counsel if necessary. Direct Kellett seconded the motion.

Mr. Knight, CSO explained every two years Business Development retains an outside independent third party firm to do a Community Physician Needs Assessment. He stated that based on that needs assessment physicians are recruited to fill those needs.

Mr. Knight provided a summary of Dr. Kushnaryov's background and experience, noting he completed his internship and fellowship at UCSD and currently resides in Santa Rosa, CA. Mr. Knight stated upon Board approval, Dr. Kushnaryov will join Dr. Lebovits and Dr. Berry's practice. He noted there is no income guarantee due to the fact that Dr. Kushnaryov is joining an established, thriving office.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

e. Approval of a Physician Recruitment Agreement with Dr. Ronald Perez

Mr. Knight provided a summary of Dr. Perez's background and experience, noting he is a family practitioner currently based in Phoenix. He stated Dr. Perez was recruited heavily by the physicians of North County Medicine and comes highly recommended by his physician colleagues. Dr. Perez is interested in setting up his practice in Carlsbad.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment Agreement with Dr. Ronald Perez, not to exceed $576,000 over two years in order to facilitate this Family Medicine physician practicing medicine in the communities served by the District.

Director Nygaard amended the motion to include "subject to review by legal counsel if necessary". The maker of the motion was in agreement of the amendment. Director Reno seconded the motion.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

f. Approval of a Physician Recruitment Agreement with Dr. Michael Pietila

Mr. Knight provided a summary of Dr. Pietila's background and experience, noting Dr. Pietila was with Sharp Mission Park for many years as well as Scripps Coastal and most recently Kaiser. Upon Board approval, Dr Pietila will join Drs. Ferber, Novak and Baroudi at the Creekview Clinic.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health of the communities served by the District to approve a Physician Recruitment Agreement with Dr. Michael Pietila not to exceed $250,000 in order to facilitate this Family Medicine physician practicing medicine in the communities served by the

District and subject to review by legal counsel if necessary. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Mr. Knight expressed his appreciation to CCO, Ms. Cheryle Bernard-Shaw for her collaboration with Business Development on these agreements.

21. Old Business

a. Report from Ad Hoc Committee on Electronic Board Portal

Director Mitchell reported the Ad Hoc Committee is finalizing their report and will be arranging a demonstration of the three potential platforms.

No action was taken.

22. Chief of Staff

a. Consideration of November 2016 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on November 28, 2016.

It was moved by Director Kellett to approve the November 2016 Credentialing Actions and Reappointments involving the Medical Staff and Allied Health Professionals, as recommended by the Medical Executive Committee at their meeting on November 28, 2016. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Approval of Cardiology, General & Vascular Surgery, Neurosurgery and Obstetrics & Gynecology Privilege Cards.

It was moved by Director Mitchell to approve the Cardiology, General & Vascular Surgery, Neurosurgery and Obstetrics & Gynecology Privilege Cards as recommended by the Medical Executive Committee on November 28, 2016. Who seconded.

Chairman Dagostino explained the physicians have been working hard to get their Privilege Cards in order and due to the fact that the Governance & Legislative

Committee did not meet this month the Privilege Cards are being brought directly to the Board for consideration.

Director Kellett commented that one of the most important jobs of the Medical Staff is determining the privileges that the physician is granted

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c. Approval of Department of Family Medicine and Department of Obstetrics & Gynecology Rules & Regulations

It was moved by Director Mitchell to approve the Department of Family Medicine and Department of Obstetrics & Gynecology Rules & Regulations as recommended by the Medical Executive Committee on November 28, 2016. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

23. Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Schallock seconded the motion.

It was moved by Director Reno to pull the minutes of the November 10th Regular meeting. Director Schallock seconded the motion.

The vote on the main motion minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

24. Discussion of items pulled from Consent Agenda

Director Reno, who pulled the minutes requested comments made by herself, Director Finnila and Director Nygaard on pages 9, 10 and 11 related to the election be included verbatim. In addition, Director Reno noted Director Kellett called the Point of Order twice during Director Finnila's comments and Chairman Dagostino called for a Point of Order on page 10.

Director Reno also noted during discussion of the CEO base salary and raise she recommended an increase to base salary from $575,000 to $625,000, if finances permit.

Ms. Donnellan indicated Director Reno's written comments will be included as an attachment to the minutes.

It was moved by Director Schallock to approve the minutes of November 10, 2016 to include Director Reno's comments as an attachment. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

25. Reports (Discussion by exception only)

26. Legislative Update

There was no Legislative Update.

27. Comments by members of the Public

Chairman Dagostino recognized staff Ms. Brenda Tavares-Ham, Ms. Chris Hart and Chief Negotiator and Labor Representative, Ms. Sarah Guerling and President of the Fire Fighter's Association, Miles Sweeney who expressed their support of the nurses and commented on the need for a better union contract that will provide for safe patient care and safe staffing practices. The speakers urged the Executive Team to listen to their concerns. Ms. Ham also read a letter into the record on behalf of Assembly Member Lorena Gonzalez who expressed her support of the nurses.

Chairman Dagostino also recognized Ms. Robin Iveson, community member who expressed her gratitude for the compassion and understanding of the Wellness Center staff during a recent incident.

28. Additional Comments by Chief Executive Officer

Mr. Dietlin welcomed our newest Board Member Leigh Anne Grass to the Board and wished everyone happy holidays.

29. Board Communications

Director Grass expressed her appreciation for the support she received from the various unions during this past election and stated that she promises to be their voice.

Director Schallock commented Drug Take Back Day in October resulted in 261 pounds of medications that will be destroyed.

Director Schallock congratulated Director Grass on her appointment and Directors Reno and Nygaard on their reappointment to the Board. He stated he is also pleased to have been re-elected for an additional term.

He expressed his appreciation to staff for rendering the quality of care they provide to our patients.

Director Nygaard reported each year the University of Arizona School of Pharmacy has the privilege of recognizing individuals on their outstanding achievements in pharmacy research and practice. This year Director Schallock received the award. Director Nygaard stated Director Schallock is a distinguished individual in the city of Oceanside and we thank him for his service

Director Nygaard reported ACHD is having their annual Leadership Academy in Sacramento in February for Board members who are interested in attending.

Director Nygaard also noted that she has a couple of articles on healthcare that she would like to share and distribute to the Board.

Director Nygaard stated we have so much to be thankful for. A wonderful community and an amazing hospital in which everyone works well together.

Director Mitchell congratulated Directors Reno Nygaard, Schallock and Grass on their appointment/reappointments to the Board.

Director Mitchell also congratulated the staff for keeping this hospital going and the physicians for their hard work.

Director Reno congratulated Directors Nygaard and Schallock on their reappointment to the Board and congratulated Director Grass on her appointment to the Board. Director Reno humbly thanked the public for reelecting her. She stated she believes this endeavor is truth that the public does trust her and thereby sitting on the Board advocating for the public.

Director Reno expressed her appreciation to all employees for their hard work, loyalty and diligence to the hospital.

Director Kellett congratulated Director Grass on her appointment to the Board and those Board members who were re-elected.

All Board members extended their best wishes for happy holidays.

30. Report from Chairperson

Chairman Dagostino extended his congratulations to the former candidates who were re-elected and new Director, Leigh Anne Grass.

Chairman Dagostino expressed his appreciation for allowing him to serve as Chairman of the Board once again and he hopes to continue to earn your trust

In closing Chairman Dagostino read a touching letter from a child whose family member received care from our Home Health nurses.

35. There being no further business Chairman Dagostino adjourned the meeting at 6:00 p.m.

James J Dagostino, DPT
Chairman

ATTEST:

Laura E. Mitchell, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

December 15, 2016 – 10:00 o'clock a.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on December 15, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Leigh Anne Grass

Also present were:

Adriana Ochoa, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Glen Newhart, Chief Development Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Mitchell led the Pledge of Allegiance.

2. Approval of agenda.

   Director Schallock left the meeting at 10:02 a.m.

   It was moved by Director Nygaard to approve the agenda as presented. Director Kellett seconded the motion. The motion passed (5-0-2) with Director Grass absent and Director Schallock absent for the vote.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Ms. Adriana Ochoa, made an oral announcement of items listed on the December 15, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

Director Schallock rejoined the meeting at 10:05 a.m.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed (6-0-1) with Director Grass absent.

6. Chairman Dagostino adjourned the meeting to Closed Session at 10:05 a.m.

8. The Board adjourned to Open Session at 2:00 p.m. with all board members present with the exception of Director Grass and Director Kellett.

9. Report from Chairperson on any action taken in Closed Session.

Chairman Dagostino reported no action had been taken in closed session.

The Board recessed briefly at 2:00 p.m.

The Board reconvened at 3:00 p.m. with all Board members present with the exception of Director Grass.

10. New Business

Consideration to approve an extension of the Medical Directorship and Physician Services Agreement with Rady Children's.

Ms. Bernard-Shaw distributed a revised Amendment to the Medical Director and Physician Services Agreement between Rady Children's Specialists of San Diego and Tri-City Healthcare District to reflect an extension of the agreement to March 31, 2017.

Ms. Schultz explained this agreement is for perinatology phone consults only and the extension is necessary to keep the patient(s) at Tri-City while we explore opportunities for this service with UCSD.

It was moved by Director Kellett that the Tri-City Healthcare Board of Directors approve the extension of the Medical Directorship and Physician Services Agreement with Rady Children's for nine (9) months through March 31, 2017 to allow time for resolution of negotiations. Director Schallock seconded the motion.

Following further discussion, Director Schallock called for the vote.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

11. There being no further business, Chairman Dagostino adjourned the meeting at 4:23 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

December 15, 2016 – 2:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 2:05 p.m. on December 15, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Leigh Anne Grass

Also present were:

Adriana Ochoa, General Legal Counsel
Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
David Bennett, Chief Marketing Officer
Glen Newhart, Chief Development Officer
Dr. Gene Ma, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Mitchell led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Nygaard to approve the agenda as presented. Director Mitchell seconded the motion. The motion passed (6-0-1) with Director Grass absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Greg Moser, made an oral announcement of item listed on the December 15, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Existing Litigation.

5. Motion to go into Closed Session

   It was moved by Director Nygaard and seconded by Director Mitchell to go into Closed Session. The motion passed (6-0-1) with Director Grass absent.

6. Chairman Dagostino adjourned the meeting to Closed Session at 2:10 p.m.

8. The Board returned to Open Session at 3:00 p.m. with all board members present with the exception of Director Grass.

9. Report from Chairperson on any action taken in Closed Session.

   Chairman Dagostino reported General Counsel has been instructed to abandon the eminent domain proceeding by a vote of 5-0-2 with Directors Grass and Reno absent. Director Reno clarified she was not absent she was recused.

10. There being no further business, Chairman Dagostino adjourned the meeting at 3:00 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

December 20, 2016 – 12:00 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 12:00 p.m. on December 20, 2016.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Finance Officer
Cheryle Bernard-Shaw, Chief Compliance Officer
David Bennett, Chief Marketing Officer
Wayne Knight, Chief Strategy Officer
Greg Moser, General Counsel
Adriana Ochoa, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino called the meeting to order at 12:00 p.m. in Assembly Rooms 2 & 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of Agenda

   It was moved by Director Kellett and seconded by Director Schallock to approve the agenda as presented. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser made an oral announcement of item listed on the December 20, 2016 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Legal Counsel related to one matter of Potential Litigation.

6. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Schallock to go into Closed Session. The motion passed unanimously (7-0).

7. Chairman Dagostino adjourned the meeting to Closed Session at 12:04 p.m.

8. The Board returned to Open Session briefly at 1:05 p.m.

9. Motion to go into Closed Session.

It was moved by Director Kellett and seconded by Director Nygaard to return to closed session. The motion passed unanimously (7-0).

10. The Board returned to open session at 1:15 p.m.

11. Chairman Dagostino reported no action was taken in Closed Session.

12. New Business

a) Consideration to approve the formation of a 1206(B) OB/GYN Clinic

It was moved by Director Mitchell to approve the ownership and management by TCHD of an OB/GYN physician clinic to be operated in Carlsbad, CA for a period of four years, including the following:

1) Execution of a Professional Services Agreement with Venus, LLC for a period of four years;

2) Execution of an asset purchase in the amount of $83,760 which will be reduced from Dr. Adib's current loan obligation to the District;

3) Execution of a 41-month, 11-day sublease of 1,558 square feet at 2067 W. Vista Way, Suite 160, Vista, CA in an amount not to exceed $212,619;

4) Approve a credit to Dr. Adib's loan for ½ of the rent and common area maintenance fees for the months of January 2016 through December 20, 2016, for an amount not to exceed $27,533.80 for space that was rented with the additional partner of the practice; and

5) Execution and delivery of all agreements and documents necessary or advisable to consummate the foregoing transactions.

Director Nygaard amended the motion to include "pending the outcome of a mutually acceptable contract." The maker of the motion accepted the amendment.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

2) AB 1234 Ethics & Compliance Training

General Counsel, Mr. Moser and Ms. Ochoa provided a two hour Ethics Training session that is mandated by AB1234 for every elected or appointed official who receives compensation or reimbursements as well as every employee or committee member, as designated by District Policy. The training included information on topics required by the Attorney General and FPPC, ensuring fairness in government laws regarding personal financial gain, laws concerning perks of office and Governance transparency rules. Board and C-suite members attending the training received a Certificate of Attendance which is valid for two (2) years. A copy of the presentation materials will be attached to the file copy of the minutes for reference.

Director Kellett left the meeting at 3:19 p.m.

Ms. Andrea Ochoa left the meeting at 3:20 p.m.

Following conclusion of the AB1234 Ethics & Compliance Training, Chief Compliance Officer, Cheryle Bernard-Shaw provided a Compliance Training Session that reviewed the following topics:

- Department of Justice Enforcement Recoveries
- False Claim Settlements FY2016
- How Does TCHD's Compliance Program Provide Protection
- What is the Board's Role in Ensuring an "Effective" Compliance Program
- Duty of Care
- Effective Compliance Programs
- 2016 OIG Guidance
- Board Responsibility
- Boards Influence on an Effective Compliance Program
- Yates Memo
- Policies & Procedures

At the conclusion of Ms. Bernard-Shaw's presentation, Ms. Bernard-Shaw reviewed policies 8610-483 – Conflicts of Interest and Acceptance of Gifts and 8750-570 – Conflicts of Interest. Ms. Bernard-Shaw also requested that the Board familiarize themselves with Board Policy 14-022 – Maintenance of Confidentiality by Directors and Committee Members. She stated breach of closed session discussions and materials is a serious issue and cannot be tolerated. Ms. Bernard-Shaw's presentation will be attached to the file copy of these minutes for reference.

Ms. Bernard-Shaw stated there will be a training session related to HIPAA at a future meeting.

Director Reno requested clarification on the 60 day rule. Ms. Bernard-Shaw explained the 60-day time frame can vary however it generally refers to overpayments. She explained the clock starts at the time an overpayment is reported.

Director Reno questioned the name of the company used for Values Line calls. Ms. Bernard-Shaw responded Global Compliance handles our Alert Line (Values Line) calls and they are reported to the Board on a quarterly basis.

2) Board of Directors Public Workshop for the purpose of Board Orientation

In the interest of time, Board members were asked to review their Board Orientation manuals which contained all Board Policies, Bylaws, Board Committee information as well as other relevant information at their leisure. Mr. Moser explained some policies are in place due to Joint Commission requirements, others mandated by state law and several are practical policies that the Board has developed themselves.

Mr. Moser noted the state recognizes liabilities Board Members may face and has the laws in place to protect and provide immunities and indemnities to Board members within the course and scope of their duties as Board members except in the case of criminal misconduct.

Director Nygaard raised a question related to Policy 14-009 Requests for Information or Assistance by Board Members. She suggested requests for information be funneled through the CEO and feedback would be given to all Board members. It was suggested the Governance Committee be directed to review Board policies as requested for revisions and or clarity.

11. Comments by members of the public.

There were no comments by members of the public.

10. **It was moved by Director Nygaard to adjourn the meeting. Director Mitchell seconded the motion. The motion passed (6-0-1) with Director Kellett absent.**

There being no further business, Chairman Dagostino adjourned the meeting at 3:55 p.m.

_____
James J. Dagostino, PT, DPT
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

CHA Health Policy Legislative Day 2017

March 14 & 15 | Sacramento

EVENT LOCATIONS

Host Hotel and Education Program

Hyatt Regency Sacramento
1209 L Street
Sacramento, CA 95814

Government Relations/Welcome Reception

Downtown & Vine
1200 K Street, #8
Sacramento, CA 95814

Breakfast Reception with Legislators

Brasserie Capitale
1201 K Street, First Floor
Sacramento, CA 95814

ACCOMMODATIONS

The Hyatt Regency Sacramento is the host hotel for the event. Rooms are available at a discounted rate of $229, single and double occupancy. For reservations, call (800) 421-1442 and mention the "California Hospital Association." The deadline to reserve a room at the discounted rate is **February 15**.

TRANSPORTATION

Cab fare from the Sacramento International Airport to the hotel is approximately $40 one way and takes about 30 minutes.

QUESTIONS

Please call the CHA Education Department at (916) 552-7637.

TUITION

This program is for executives of CHA member hospitals only and the deadline to register is **February 15**. To encourage members to register by the deadline, registration fees are discounted.

Member rate by February 15..... $245
Member rate after February 15..... $345

CONFIRMATIONS

A confirmation will be emailed to all registrants. Participants will be emailed their schedule of appointments with the legislators one week prior to the program.

CANCELLATION POLICY

A $50 non-refundable processing fee will be retained for each cancellation received in writing by March 8. No refunds will be made after this date. Substitutions are encouraged. Cancellation and substitution notification may be emailed to education@calhospital.org.

AMERICANS WITH DISABILITIES ACT

If you require special accommodations pursuant to the Americans with Disabilities Act, contact CHA at (916) 552-7637.

CALIFORNIA HOSPITAL ASSOCIATION
Leadership in Health Policy and Advocacy

1215 K Street, Suite 800
Sacramento, CA 95814
(916) 443-7401

www.calhospital.org

CHA Health Policy Legislative Day 2017

March 14 & 15 | Sacramento

registration form

Three ways to register

ONLINE
Register online at www.calhospital.org/Legislative-Day

MAIL
California Hospital Association
Education Department
1215 K Street, Suite 800
Sacramento, CA 95814

Make check payable to CAHHS/CHA.

FAX
Fax your registration to (916) 552-7506 with your credit card information.

Cancellation Policy:
A $50 non-refundable processing fee will be retained for each cancellation received in writing by March 8. No refunds will be made after this date. Substitutions are encouraged. Cancellation and substitution notification may be emailed to education@calhospital.org.

Special Accommodations or Questions:
If you require special accommodations pursuant to the Americans with Disabilities Act or have other questions, please call CHA at (916) 552-7637.

Tuition:
This program is for executives of CHA member hospitals only. To facilitate the scheduling of appointments with the Legislature, please register by **February 15**.

☐ Member rate by February 15 ..... $245
☐ Member rate after February 15 ..... $345

Payment:

☐ Check enclosed. Make check payable to CAHHS/CHA.
☐ Credit card (check one): ☐ VISA ☐ MC ☐ AMEX

Card Number: _____

Name on Card: _____

Expiration Date: _____ Security Code: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Authorizing Signature: _____

CALIFORNIA HOSPITAL ASSOCIATION

Registrant Information:

Name: _____

Title: _____

Hospital / Organization: _____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____

Email Address (required): _____

CC Email Address (optional): _____

Dietary Request: ☐ Vegetarian

Food Allergies: _____

Events on Tuesday, March 14:

If you are attending the Tuesday program, please check the events you plan to attend:

☐ New Participant Briefing
☐ Team Leader Briefing
☐ VIP Tour of the State Capitol
☐ Government Relations/Welcome Reception

CHA will Schedule Legislative Meetings on Your Behalf

CHA's advocacy staff will schedule appointments with members of the Legislature on your behalf — primarily group meetings with other hospital executives from your area. Scheduling will be coordinated with input from the Regional Associations. Hospital executives are asked not to schedule meetings directly with representatives.

If you would like appointments with specific legislators from districts other than your own, please indicate your requests below. Every effort will be made to accommodate your requests.

_____

_____

_____

☐ **Do Not Schedule Meetings.** If you will not attend the meetings with legislators on Wednesday afternoon, please check the box and CHA will not schedule appointments on your behalf.

Questions: If you have questions about the appointments or have other special requests, contact your regional hospital association vice president or Patricia Ward at the CHA office at pward@calhospital.org or (916) 552-7526.

HCCA
HEALTHCARE COMPLIANCE ASSOCIATION

Board *Audit Committee* Compliance Conference

February 27–28, 2017

Scottsdale, AZ | The Scott Resort & Spa

Questions? catherine.stollenwerk@corporatecompliance.org

hcca-info.org/audit

Buy one registration for $895 and get one for $595

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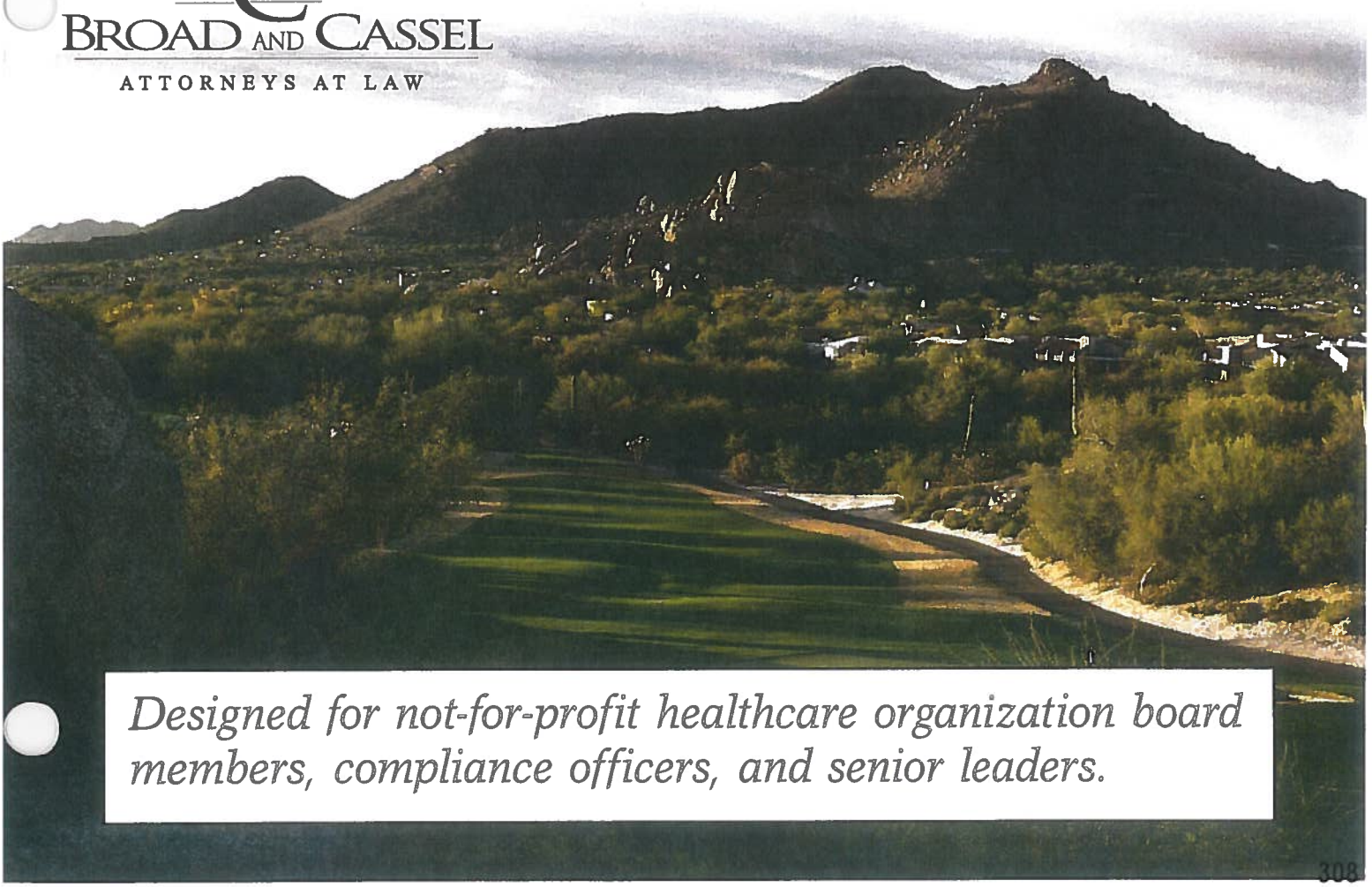
ATTORNEYS AT LAW



Designed for not-for-profit healthcare organization board members, compliance officers, and senior leaders.

Agenda

MONDAY, FEBRUARY 27

7:30 AM – 5:45 PM
Registration

7:30 – 8:15 AM
Continental Breakfast

8:15 – 8:30 AM
Opening Remarks

8:30 – 10:00 AM
Introduction to Healthcare Risk Areas & Compliance

DANIEL R. ROACH
General Counsel &
Chief Compliance Officer
Optum360

- Key healthcare risks
- The case for compliance & ethics programs
- Compliance fundamentals
- The board's role in compliance & ethics programs

10:00 – 10:15 AM
15-Minute Break

10:15 – 11:15 AM
Introduction to Healthcare Accounting

URTON ANDERSON, CCEP
Director
Von Allmen School of Accountancy

LAURIE LAFONTAINE, CPA
Board Member
Presence Health and North Memorial Healthcare

- Understand the complexity of healthcare industry and accounting
- Gain an understanding of the numerous areas impacting healthcare accounting
- Top accounting issues facing audit committees

11:15 – 11:30 AM
15-Minute Break

11:30 AM – 12:30 PM
Stark and Anti-Kickback

RYAN MEADE, CHRC, CHC-F
Director of Regulatory Compliance Studies, Loyola University Chicago School of Law

- Provide an overview of each law, including discussion of recent enforcement actions
- Discuss similarities and differences in the two laws
- Discuss strategies that can be implemented to promote compliance

12:30 – 1:30 PM
Lunch (provided)

1:30 – 2:30 PM
Case Studies in Crisis Management

DANIEL R. ROACH
General Counsel &
Chief Compliance Officer
Optum360

- Planning for and dealing with the inevitable crisis

2:30 – 2:45 PM
15-Minute Break

2:45 – 3:45 PM
What It Takes to Be a Good Board Member

Moderator:

DENISE BURKE, CHC
Partner
Waller Lansden Dortch & Davis LLP

Panelists:

ANDY TAGGART
Attorney
Taggart, Rimes & Graham, PLLC

JAMES SHEEHAN, Esq.
Chief, Charities Bureau
New York State Office of the Attorney General

- Compliance and board member duties in compliance investigation
- Board member oversight of mergers and acquisitions
- The relationship between the board and the C-suite

3:45 – 4:00 PM
15-Minute Break

4:00 – 5:00 PM
Enterprise Risk Management

SHANNON SUMNER, CPA, CHC
Principal and Shareholder
Pershing Yoakley & Associates, PC

KIMBERLY LANSFORD
Chief Compliance Officer
Shriners Hospitals for Children

- The board's role with Enterprise Risk Management (ERM)
- Effective ERM in today's healthcare setting
- When ERM fails: "The perfect storm"

5:00 – 5:30 PM
Q&A Session

ALL SPEAKERS

5:30 – 6:30 PM
Networking Reception

TUESDAY, FEBRUARY 28

7:30 – 11:30 AM
Registration

7:30 – 8:00 AM
Continental Breakfast

8:00 – 9:15 AM
Whistleblower Case Study

GABRIEL IMPERATO, Esq., CHC
Managing Partner
Broad and Cassel

Lesley Ann Skillen
Attorney
Getnick & Getnick LLP

- Whistleblowers; Who are they and why do they file Qui Tam cases?
- Can Health Care Organizations Manage this Risk?
- Tips for Compliance Program Effectiveness

9:15 – 9:30 AM
15-Minute Break

9:30 – 10:30 AM
Privacy and Security of Healthcare Information

DARRELL CONTRERAS, Esq., LHRM, CHC-F, CHRC, CHPC
Chief Compliance Officer
Millennium Health

- The basics of HIPAA Privacy and Security
- Board responsibilities for the Privacy and Security program
- What to expect when something goes wrong

10:30 – 10:45 AM
15-Minute Break

10:45 – 11:30 AM
Fraud & Abuse and Compliance 2017

GABRIEL IMPERATO, Esq., CHC
Managing Partner
Broad and Cassel

- Recent Developments in Enforcement and Compliance
- Individual Accountability for Organizational Health Care Fraud
- Department of Justice Compliance Counsel and Enforcement and Compliance in the New Administration.

11:30 AM
Boxed Lunches to Go

PLEASE NOTE:
Agenda and speakers are subject to change.

Registration

Board Audit Committee Compliance Conference | February 27–28, 2017 | Scottsdale, AZ

CONTACT INFORMATION

○ Mr. ○ Mrs. ○ Ms. ○ Dr.

HCCA Member ID *(if applicable)*

First Name MI

Last Name

Credentials *(CHRC, CHC, etc.)*

Job Title

Name of Employer

Street Address

City State Zip Code

Phone

Email *(required for registration confirmation & conference information)*

REGISTRATION OPTIONS

(Registration fees are as listed and considered net of any local withholding taxes applicable in your country of residence.)

☐ Conference Registration $895

☐ Conference Registration & HCCA Membership $1095
Join HCCA and SAVE $95 off your first year! Annual dues $295. New members only.

☐ Conference Registration: Second Attendee $595

☐ Conference Registration & HCCA Membership: Second Attendee $795

TOTAL $ _____

Code: _____ 2nd Attendee: _____

Organizations may receive one registration at $595 for every one registration purchased at $895. To receive this offer, write 2AAC0217 in the space for the code above and write the name of the person with whom you are attending. Offers may not be combined. Both attendees must complete separate registration forms.

SPECIAL REQUEST FOR DIETARY ACCOMMODATION

○ Gluten Free
○ Kosher
○ Vegetarian
○ Vegan
○ Other _____

PAYMENT OPTIONS

○ Check *(mail to HCCA, 6500 Barrie Road, Suite 250, Minneapolis, MN 55435)*
○ Invoice me
○ I authorize HCCA to charge my credit card *(choose below)*

Due to PCI Compliance, please **do not provide any credit card information via email**. You may email this form to helpteam@hcca-info.org (without credit card) and call HCCA at 888-580-8373 or 952-988-0141 with your credit card.

CREDIT CARD: ○ American Express ○ Discover ○ MasterCard ○ Visa

Credit Card Account Number

Credit Card Expiration Date

Cardholder's Name *(please print)*

Cardholder's Signature

AAC0217

REGISTRATION TERMS

Payment: Please make your check payable to HCCA. Enclose payment with your registration and return it to HCCA's office, or fax your credit card payment to 952-988-0146. If your total is miscalculated, HCCA will charge your card the correct amount.

Cancellations and substitutions: You may send a substitute in your place or request a conference credit, refunds will not be issued. Conference credits are issued in the full amount of the registration fees paid and are good for 12 months from the date of the cancelled event. Conference credits may be used towards any HCCA service. If you need to cancel your participation, notify us prior to the start date of the event by email at helpteam@hcca-info.org or by fax at 952-988-0146. Please note that if you are sending a substitute, an additional fee may apply.

Tax deductibility: All expenses incurred to maintain or improve skills in your profession may be tax deductible; including tuition, travel, lodging and meals. Please consult your tax advisor.

Recording: No unathorized audio or video recording of HCCA conferences is allowed.

Special needs/concerns: Prior to your arrival, please call HCCA at 888-580-8373 if you have a special need and require accommodation.

HOTEL & CONFERENCE LOCATION

The Scott Resort & Spa (formerly FireskyResort & Spa)
4925 North Scottsdale Road, Scottsdale, AZ 85251
www.thescottresort.com

A reduced rate of $279.00 per night plus applicable occupancy and sales taxes (currently 13.92%, subject to change) for single/double occupancy. The hotel resort fee is included in your room rate and includes self- parking, Wi-Fi in guest rooms and public space, coffee service in hotel living room, seasonal nonalcoholic beverages served in hotel living room and Paradise Pool, S'mores to enjoy by fire pits, 24 hour fitness center and business center access and Daily newspaper upon request. To book your reservations online go to http://bit.ly/Scott17, or call the hotel directly at 480.945.7666 or 866. 267.1321 and request the HCCA Board Audit Committee Compliance Conference rate. The cutoff date for the group rate is Friday, February 3, 2017 or once the group room block is full, whichever comes first.

CONTINUING EDUCATION UNITS

HCCA is in the process of applying for additional credits. If you do not see information on your specific accreditation and would like to make a request, please contact us at 952-988-0141 or 888-580-8373 or email ccb@compliancecertification.org. Visit HCCA's website, www.hcca-info.org for up-to-date information.

AAPC: This program has the prior approval of the AAPC for 10.0 continuing education hours. Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

ACHE: The Health Care Compliance Association is authorized to award 9.0 hours of pre-approved ACHE Qualified Education credit (non-ACHE) for this program toward advancement, or recertification in the American College of Healthcare Executives. Participants in this program wishing to have the continuing education hours applied toward ACHE Qualified Education credit should indicate their attendance when submitting and application to the American College of Healthcare Executives for advancement or recertification.

Compliance Certification Board (CCB): CCB has awarded a maximum of 11.4 CEUs for these certifications: Certified in Healthcare Compliance (CHC)®, Certified in Healthcare Compliance–Fellow (CHC-F)™, Certified in Healthcare Privacy Compliance (CHPC)®, Certified in Healthcare Research Compliance (CHRC)®, Certified Compliance & Ethics Professional (CCEP)®, Certified Compliance & Ethics Professional–Fellow (CCEP-F)®, Certified Compliance & Ethics Professional–International (CCEP-I)™

CLE: The Health Care Compliance Association is a State Bar of California Approved MCLE provider, a Pennsylvania Accredited Provider, and a Texas Accredited Sponsor. An approximate maximum of 9.5 clock hours of CLE credit will be available to attendees of this conference. All CLE credits will be awarded based on individual attendance.

NASBA/CPE: The Health Care Compliance Association is registered with the National Association of State Boards of Accountancy (NASBA) as a sponsor of continuing professional education on the National Registry of CPE sponsors, Sponsor Identification No: 105638. State boards of accountancy have final authority on the acceptance of individual courses for CPE credit and may not accept one-half credits. Complaints regarding registered sponsors may be addressed to the National Registry of CPE Sponsors, 150 Fourth Avenue North, Suite 700, Nashville, TN 37219-2417. Website: www.nasba.org. A recommended maximum of 11.0 credits based on a 50-minute hour will be granted for the entire learning activity. This program addresses topics that are of a current concern in the compliance environment. This is an update, group-live activity. For more information regarding administrative policies such as complaints or refunds, call (888) 580-8373 or (952) 988-0141.

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HEALTH CARE COMPLIANCE ASSOCIATION

6500 Barrie Road, Suite 250, Minneapolis, MN 55435
P 888-580-8373 | F 952-988-0146
www.hcca-info.org | helpteam@hcca-info.org

HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

Health Care Compliance Association
6500 Barrie Road, Suite 250
Minneapolis, MN 55435
www.hcca-info.org
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Board *Audit Committee* Compliance Conference

February 27-28, 2017
Scottsdale, AZ | The Scott Resort & Spa

Buy one registration for $895 and get one for $595

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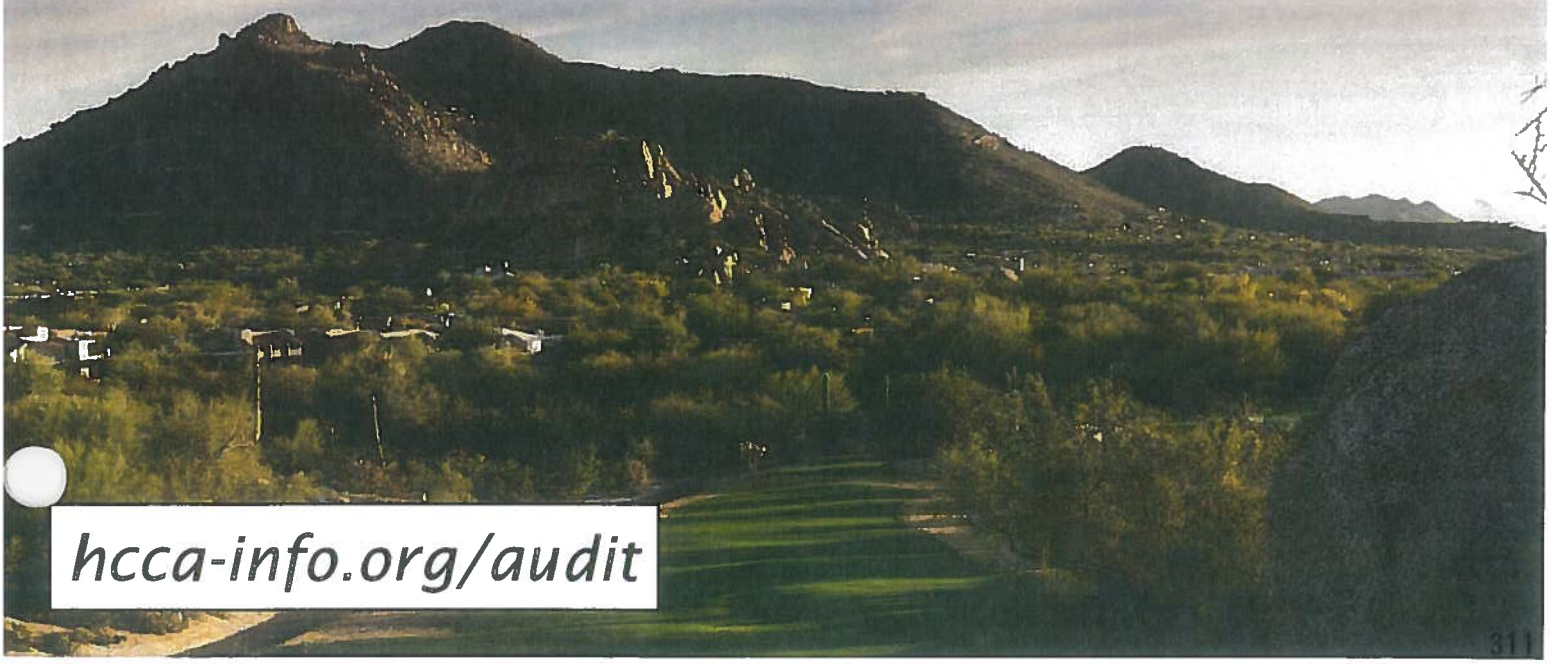
HEALTH CARE COMPLIANCE ASSOCIATION

Board *Audit Committee* Compliance Conference

February 27-28, 2017



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Steven Dietlin
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Invoice:	45268
Date :	12/7/2016
Client :	HCA011
Due Date:	1/6/2017

Service/Product	Service Dates	Amount
The Governance Institute Limited Membership	Feb 2017 - Jan 2018	$23,475.00
	Sub Total	$23,475.00
	Total	$23,475.00

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MEMBERSHIP SERVICES AGREEMENT

The purpose of this Agreement is to outline membership benefits, pricing, and Terms & Conditions (which are attached hereto and incorporated herein by this reference) with National Research Corporation d/b/a The Governance Institute. Your signature below provides confirmation and acceptance of the Terms & Conditions, as well as the Summary of Benefits and pricing. Please return the executed Agreement to the attention of Justin Burns either via facsimile to (858) 646-3457 or via e-mail to: jburns@GovernanceInstitute.com.

X The Governance Institute Legacy Membership $23,475.00

Notes:

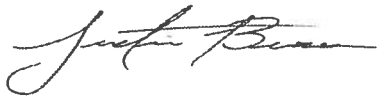
- ***Payment will be due 30-days from the date of invoice. The Governance Institute will continue to renew your membership annually each February; a yearly fee increase of 5% may be applied.***
- ***The Benefits set forth below are available for use by only one board (the signatory to this Agreement). Access to such Benefits may be granted to other system boards for an additional fee.***

SUMMARY OF BENEFITS: Membership grants access to trusted, independent information and resources for hospitals and health system board members, healthcare executives, and physician leaders in support of efforts to lead and govern your organizations.

- Custom governance research by request
- One self-assessment of board performance *(BoardCompass®)*
- Unlimited access to The Governance Institute's Interactive web site which includes a library of on-demand publications, research, and multi-media resources
- Access to a vetted directory of expert speakers on governance, leadership, and industry topics
- The Governance Institute Advisory Services *(fees vary based on project scope)*
- Seven tuition-free leadership conference passes for the year
- Governance Support Program
  - One tuition-free pass to our annual Governance Support Conference
  - Online Governance Support Forum which includes online resources, templates, and the Elements of Governance Support® series

We sincerely appreciate the opportunity to serve you, your organization and Board of Directors. If you have any questions, please do not hesitate to contact me at (877) 712-8778 or by e-mail at the address above.

Sincerely,



Justin Burns
Business Development Manager
NRC d/b/a The Governance Institute

TERMS AND CONDITIONS

The following provisions are an integral part of the Agreement between National Research Corporation d/b/a The Governance Institute (hereinafter referred to as "TGI") and Member.

1. CONFIDENTIAL INFORMATION. Except as Member may authorize in writing, TGI and its employees shall: (a) treat and cause to be treated as confidential, all information furnished by Member to TGI which has been marked as proprietary or confidential information of Member; (b) limit access to such confidential information to TGI employees and TGI supervisory and support personnel; (c) neither use nor copy any confidential information except with the approval of Member or to the extent necessary for performance of the Services hereunder; and (d) not disclose to any third party the identity of any patient of Member.

2. LIMITED WARRANTY; LIMITATION OF LIABILITY.

(a) TGI warrants that the Services will be performed in a good and workmanlike manner, and that the Services will conform substantially to the MEMBERSHIP SERVICES AGREEMENT. TGI's sole obligation under this warranty is to correct and adjust the Services within a reasonable time from notification by Member that such Services do not substantially conform to this warranty.

(b) TGI'S LIABILITY AND MEMBER'S EXCLUSIVE REMEDY FOR DEFECTIVE PERFORMANCE OR NON-PERFORMANCE OF THIS AGREEMENT SHALL BE LIMITED TO CORRECTION AND ADJUSTMENT OF THE SERVICES WHICH DO NOT COMPLY WITH THIS WARRANTY, PROVIDED THAT MEMBER AFFORDS TGI A REASONABLE OPPORTUNITY TO PROVIDE SUCH CORRECTIONS AND REASONABLY ASSISTS TGI IN IDENTIFYING SUCH ERRORS OR OMISSIONS.

(c) THE LIMITED WARRANTY PROVIDED IN SUB-PARAGRAPHS (a) AND (b) HEREOF IS IN LIEU OF ALL OTHER EXPRESS WARRANTIES AND ANY IMPLIED WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR COURSE OF DEALING OR USAGE OF TRADE, ALL SUCH WARRANTIES BEING EXPRESSLY DISCLAIMED BY NRC.

(d) IN NO EVENT SHALL TGI BE OBLIGATED OR LIABLE TO MEMBER FOR ANY CONSEQUENTIAL, INCIDENTAL, INDIRECT, SPECIAL OR PUNITIVE DAMAGES ARISING OUT OF OR IN CONNECTION WITH THE SERVICES PROVIDED BY TGI TO MEMBER HEREUNDER, INCLUDING BUT NOT LIMITED TO LOSS OF REVENUE OR PROFIT, EVEN IF TGI HAS BEEN ADVISED OR KNEW OR SHOULD HAVE KNOWN OF THE POSSIBILITY OF SUCH DAMAGES OR LOSS.

3. LICENSES.

(a) Subject to Member's compliance with the terms and conditions of this Agreement, TGI hereby grants Member a non-exclusive license during the term of this Agreement to use the Services described in the MEMBERSHIP SERVICES AGREEMENT and any deliverables associated with the Services (the "Deliverables"). Deliverables shall not include data provided by Member to TGI which shall remain the sole property of Member. This license is granted conditional upon the payment to TGI of the applicable Membership Fee in accordance with the terms and conditions of invoices provided by TGI to Member. In the event of delinquency in payment of any Membership Fee, any rights granted to Member to use the Deliverables shall be revoked. Except as specifically set forth herein, TGI retains all right, title, and interest, including all intellectual property rights, relating to or embodied in the Services and the Deliverables, including without limitation all technology, telephone numbers, web addresses, software, printed material, associated media, documentation, or systems relating to the Services and Deliverables. Member agrees not to reverse engineer, decompile, disassemble, translate, or attempt to learn the source code of any software related to the Services. Unauthorized reproduction shall be cause for immediate termination of the License and this Agreement. Only Member and its authorized employees, agents or representatives shall be entitled to inspect, use or examine the Deliverables. Member shall not sell, transfer, exchange, sub-license or disclose the Deliverables to any third party whatsoever without the prior written consent of TGI, and shall establish and follow appropriate security measures to safeguard and prevent any unauthorized disclosure which shall be at least equal to the security measures taken by Member to safeguard its own confidential and proprietary information.

(b) Subject to Member's compliance with the terms and conditions of this Agreement, NRC's board portal Licensors ("Licensors") hereby grant to Member a limited, non-exclusive, non-transferable right to access and use a board portal product ("Portal") during the term of this Agreement solely for Member's internal use, and solely for the period for which Member has paid the applicable Membership Fees under this Agreement. Member agrees that it will not (1) make the Portal available to, or use the Portal for the benefit of, any third party, (2) modify, sell, resell, license, sublicense, distribute, rent or lease the Portal, or include the Portal in a service bureau or outsourcing offering, (3) use the Portal to store or transmit infringing, libelous, or otherwise unlawful or tortious material, or to store or transmit material in violation of third-party privacy rights, (4) use the Portal to store or transmit malicious code, (5) interfere with or disrupt the integrity or performance of the Portal or any third-party data contained therein, (6) attempt to gain unauthorized access to the Portal or its related systems or networks, (7) permit direct or indirect access to or use of the Portal in a way that circumvents a contractual usage limit, (8) copy or reproduce the Portal or any part, feature, function or user interface thereof, (9) frame or mirror any part of the Portal, or (10) access the Portal in order to build a competitive product or service, or (11) reverse engineer, decompile or otherwise attempt to determine the source code or algorithms of the Portal (to the extent such restriction is permitted by law), (12) delete or alter the proprietary rights notice appearing on the Portal. Member

agrees to hold the Portal in confidence and will protect the same with at least the same degree of care with which the Member protects its own similar confidential information. Member acknowledges that both NRC and Licensors disclaim any warranty of any kind directly to Member, including any warranty of title, merchantability, fitness for a particular purpose or non-infringement. In no event will the Licensors be liable for any damages directly to the Member, whether direct or indirect, incidental or consequential, arising in connection with this Agreement and/or the Member's use of the Portal.

4. TERMINATION. Upon either party's failure to cure a material breach of this Agreement within thirty (30) days following written notice thereof from the other party, the non-breaching party may terminate this Agreement effective at the end of such thirty (30) day period. Either party may, at its option by written notice, terminate this Agreement immediately upon the other party's insolvency, inability to pay its debts when due, assignment for the benefit of creditors, ceasing to do business as a going concern, filing for protection of the bankruptcy laws, becoming the subject of any involuntary proceeding under federal bankruptcy laws, or upon the appointment of a receiver or trustee. In the event that Member terminates this Agreement for any reason by providing TGI with ninety (90) days written notice prior to the date of renewal (the "Termination Date"), Member shall pay all fees due and owing to TGI under the Agreement through the Termination Date. In the event of termination, TGI will cease all Services and work in progress as of the Termination Date. The Member may opt to have TGI continue work in progress and associated Services until completed, so long as Member has paid all fees due and owing to TGI at that time. In such event, the Member agrees to pay a fee for activities completed by TGI beyond the Termination Date that shall not be greater than the prorated Membership Fee currently in effect. Services to be completed and associated fees will be agreed upon in writing no later than thirty (30) days prior to Termination Date. Any prepaid fees in excess of the work performed or to be performed will be refunded to the Member after work has ceased. Without prejudice to any other rights, TGI may immediately terminate this Agreement in the event that Member does not cure a failure to timely pay any invoice, and in such event, Member agrees to immediately cease any use of the Deliverables and to immediately return the Deliverables and all copies thereof to TGI. Failure to exercise, or any delay in exercising, this right to terminate for failure to pay shall not constitute a waiver of that or any other right or remedy, nor shall it preclude or restrict any further exercise of that or any other right or remedy.

5. SECURITY.

(a) The Parties agree to implement the Security Rule (security standards as set out in 45 C.F.R. parts 160, 162 and 164), Administrative, Physical and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of any electronic Confidential Information that is created, received, maintained or transmitted throughout contract term.

(b) The Parties agree to report any security incident of which it becomes aware in writing within three (3) business days.

(c) The Parties agree to ensure that any agent, including a subcontractor, to whom it provides Confidential Information, receives from, or creates or receives by, on behalf of the other Party, agrees to the same restrictions and conditions that apply through this Agreement with respect to such information.

(d) The Parties agree to make their policies, procedures, and documentation relating to the safeguards described herein available to the Secretary, for purposes of determining compliance with Security Rule.

6. COUNTERPARTS AND ELECTRONIC SIGNATURES. This Agreement may be executed in several counterparts, each of which shall constitute one and the same instrument, and shall become effective when counterparts have been signed by each of the parties; it being understood that all parties need not sign the same counterparts. The signatures of the authorized representatives of the parties to this agreement which are scanned and sent by electronic mail or sent by facsimile transmission to the other party shall have the same force and effect as original signatures. Electronic signatures of the parties transmitted by electronic mail shall be deemed to be their original signatures for all purposes.

7. MISCELLANEOUS.

(a) The Membership Services Agreement may be supplemented, modified or amended only by a written instrument duly executed by authorized representatives of each of the parties.

(b) TGI shall maintain and provide evidence of general liability, property, automobile, and workers' compensation insurance coverages. Upon request, a current certificate of insurance shall be provided upon execution of the Agreement and as policies are renewed or changed.

(c) This Agreement is not intended to create a joint venture, partnership, or association of any kind between the parties and the relationship of the parties under this Agreement is that of independent contractors. TGI agrees that the persons retained by it to provide Services hereunder are TGI employees and are not employees of Member for any purpose, and therefore, such persons are not entitled to any rights or benefits, whether present or future, under any retirement plan of Member; or the payment by Member of social security taxes, workers' compensation premiums, unemployment insurance premiums, overtime or other compensation, and any other employee benefits, including withholding of federal or state income taxes, and that TGI shall be solely responsible for these obligations.

(d) The waiver by one party of the performance of a covenant, condition or promise, or a failure to enforce a breach of any provision hereof under the Agreement shall not invalidate the Agreement nor shall it be considered a waiver by such party of any other

covenant, condition or promise, nor shall any such waiver be construed as future waiver of the performance of any other like act, covenant, condition or promise. No waiver shall be binding unless executed in writing by the party making the waiver.

(e) In the event that any provision of the Agreement shall be invalid or prohibited under applicable law, such provision(s) shall be ineffective only to the extent of such prohibition and the remaining provisions of the Agreement shall continue in effect.

(f) This Agreement shall be governed by and construed in accordance with the laws of the state in which Member's principal place of business is located, without giving effect to the principles of choice of law of such state; provided, however, that in the event that Member initiates litigation against TGI relating to the subject matter of this Agreement, the laws of the state of Nebraska shall govern, without giving effect to the principles of choice of law of such state.

(g) All notices of any kind required or permitted under this Agreement shall be in writing and shall be delivered by mailing a copy thereof by certified or registered United States mail, postage prepaid, with return receipt requested, or by overnight express delivery.

(h) If either party is prevented from performed any portion of this Agreement (except obligations for the payment of money) by causes beyond its control, such party shall be excused for a period of time equal to the duration of the conditions causing such delay.

(i) TGI is the sole owner of the Deliverables, including any adaptations or copies thereof, and all intellectual property rights associated therewith. The title and copyright in and to the Deliverables, and any copies thereof, are also owned by TGI. The Deliverables are protected by copyright laws and international treaty provisions. Therefore, Member shall treat the Deliverables like any other copyrighted matter, subject to the provisions of this Agreement. Member acknowledges TGI's right to injunctive relief in case of breach of this Agreement, in addition to any remedy for damages. The failure of any party to enforce any provision hereof shall not be a waiver of the rights of such party to thereafter enforce any such provision.

(j) Unless otherwise objected to by Member, TGI shall be allowed to use Member's name and logo on TGI's website, social media sites, and in other marketing and promotional materials for the sole purpose of identifying Member as a member of TGI. TGI will not use Member's name or logo in any manner not provided for under this Agreement without Member's prior consent.

National Research Corporation d/b/a
The Governance Institute
1245 Q Street
Lincoln, NE 68508

By: _____

Printed Name: _____

Title: _____

Date: _____

Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056-4506

By: _____

Printed Name: _____

Title: _____

Date: _____

Stakeholder Experience

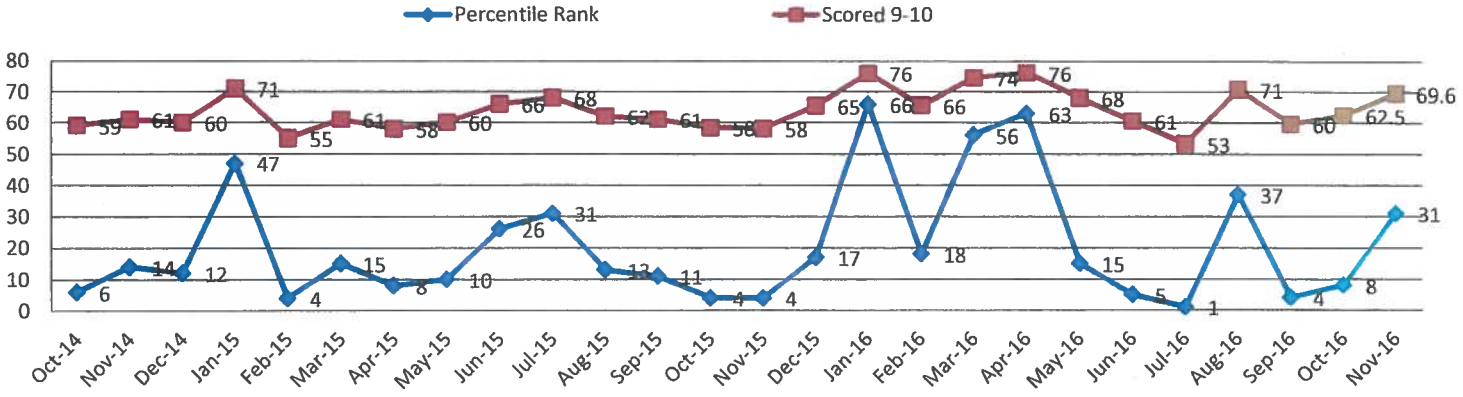
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

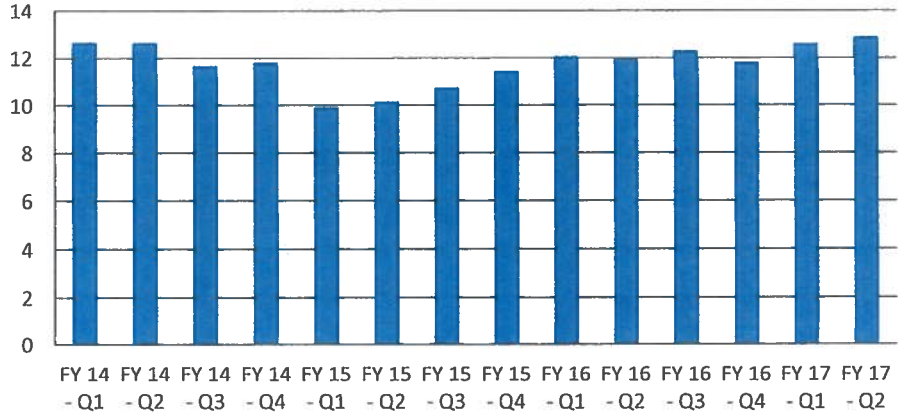
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

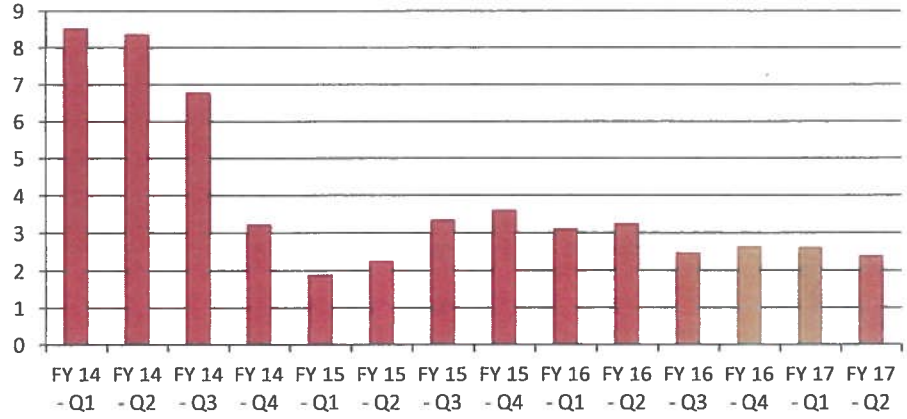
Overall Rating of Hospital (0-10)



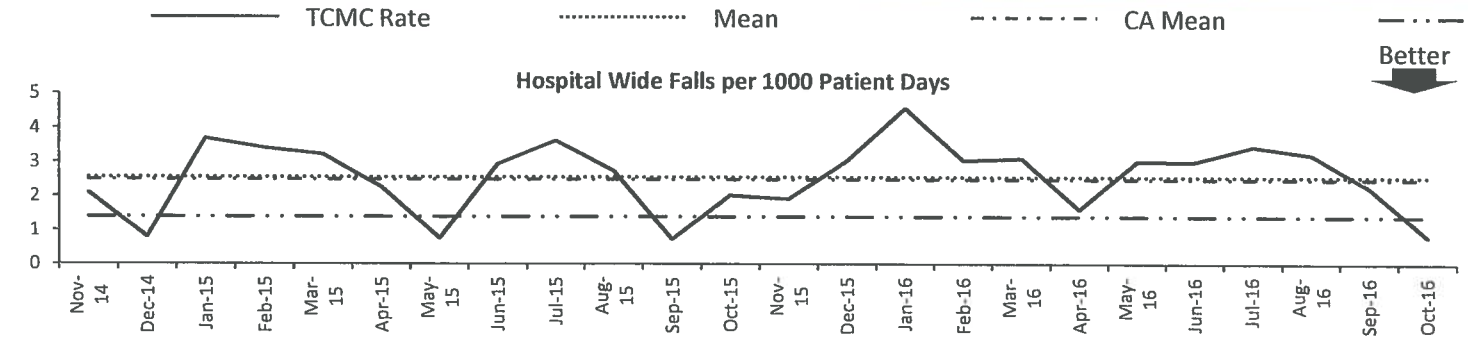
Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



Fall & HAPU's

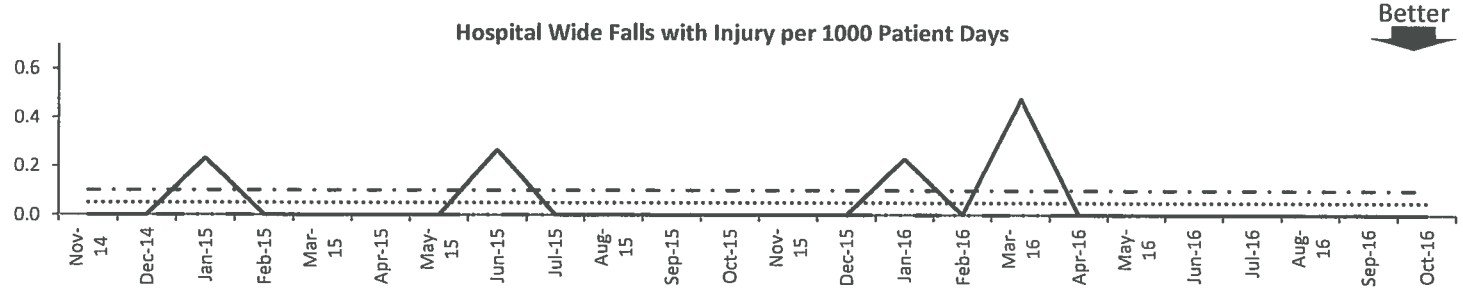


Action Plan

45 CHARMS Mnemonic Poster created by Maria Coy RN, Telemetry ANM (See below)

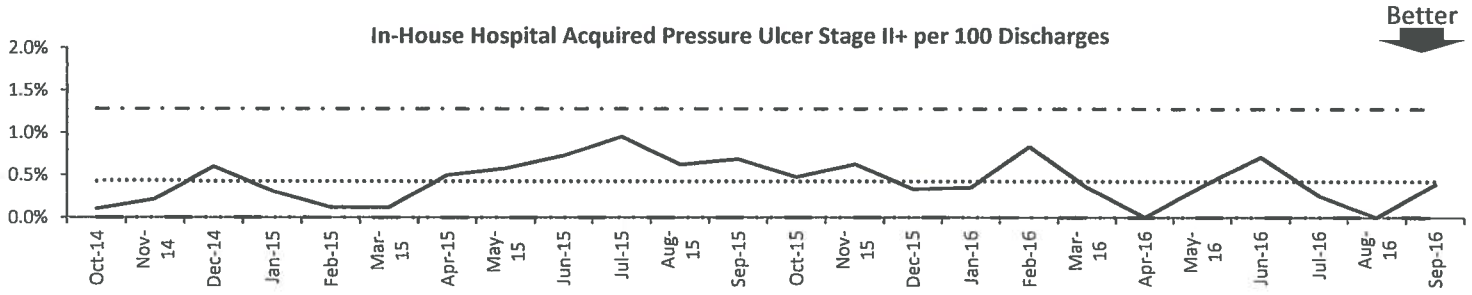
Implement revised protocol for Progressive Care Unit, ED, ICU, WCS, and Ambulatory Units

Continue to monitor compliance



Action Plan

45: >45 Fall Risk Assessment
C: Call Lights answered immediately
H: Hand-off of high risk patients
A: Assist woth Toileting and Activities
R: Rounding
M: Magnets and Signs visible
S: Sign Safety Plan for all Patients

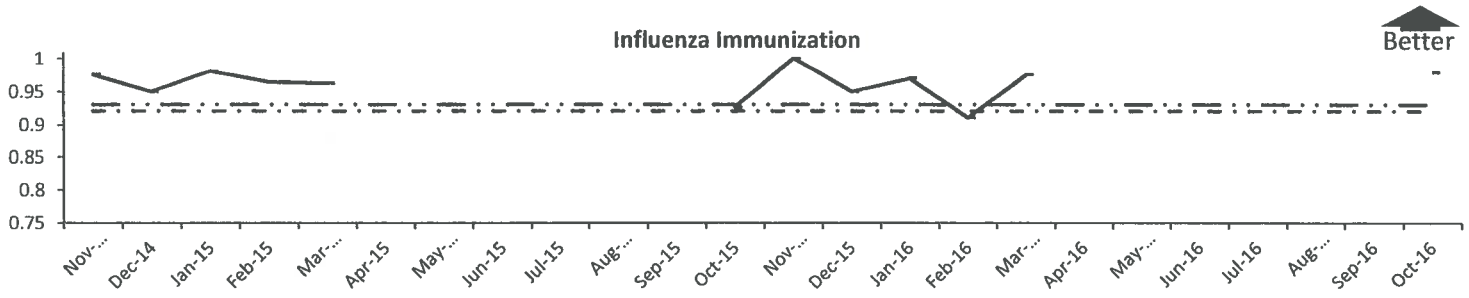


Action Plan

New Capture cameras deployed to all units with good feedback.
FOCUS PDCA project initiation for skin assessment.
Skin champions designated for ICU and Tele.
Working with ACS, ED, and PCU to recruit skin champions.

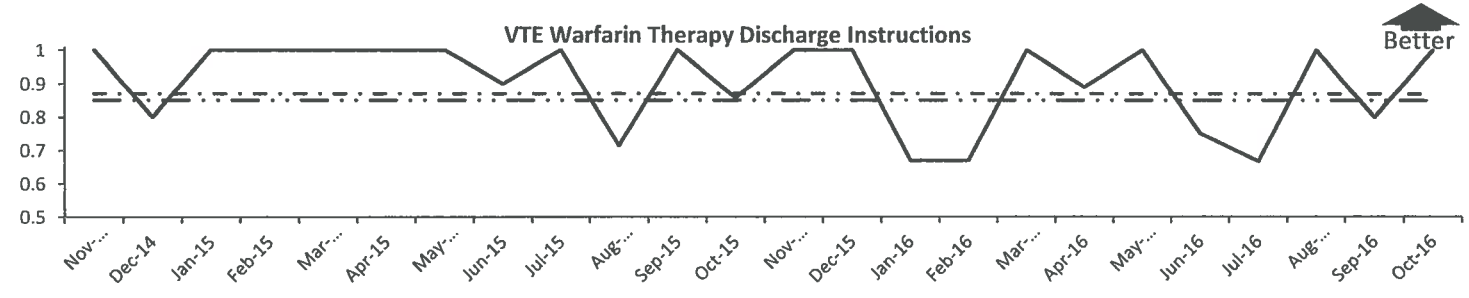
Core Measures

TCMC Rate ····· Mean — · — · — CA Mean — · · — · · — TCMC Target



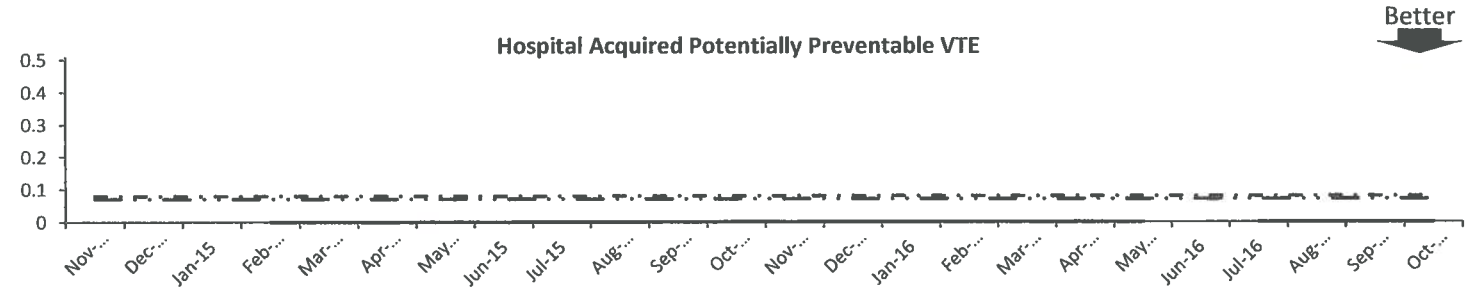
Action Plan

October starts the new Flu season and we started with a 98% pass rate. This is well above target.



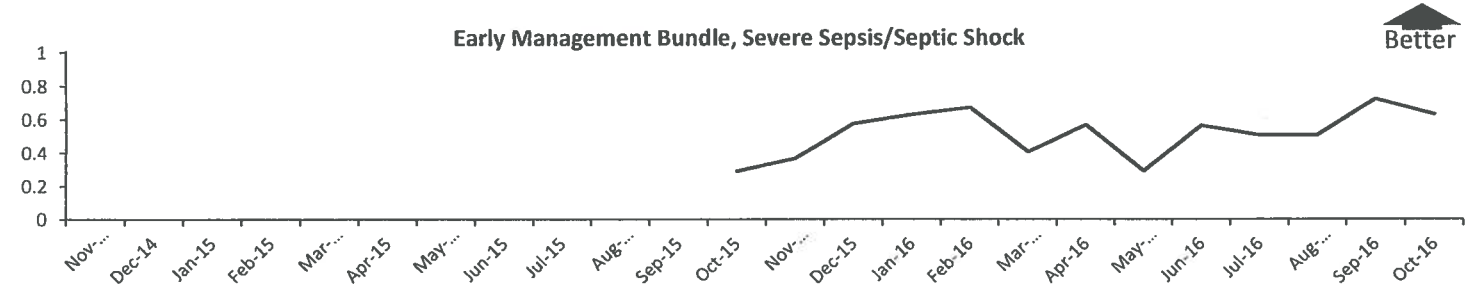
Action Plan

100%



Action Plan

Consistently at zero (perfect)

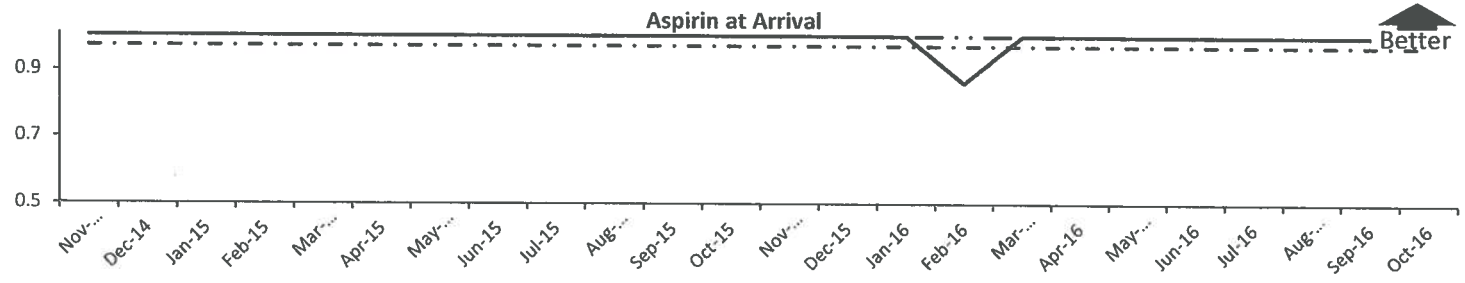


Action Plan

Small numbers. 5 of 8. Upward trend. Oct 1 failure was procedural issues that have been corrected. Repeat lactate now being drawn in ED. 2nd failure had start time after admission to floor. Post admission is our next focus for improvement.

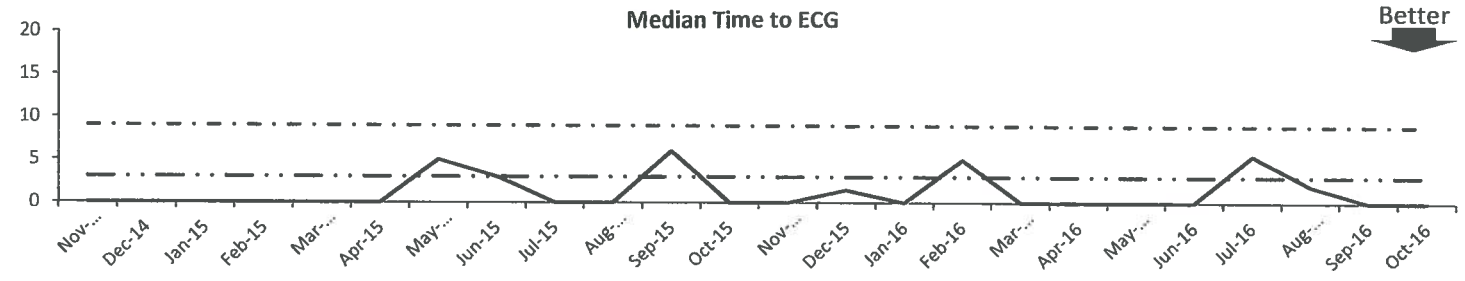
Core Measures

TCMC Rate ..... Mean — · — · — CA Mean — · · — · · — TCMC Target



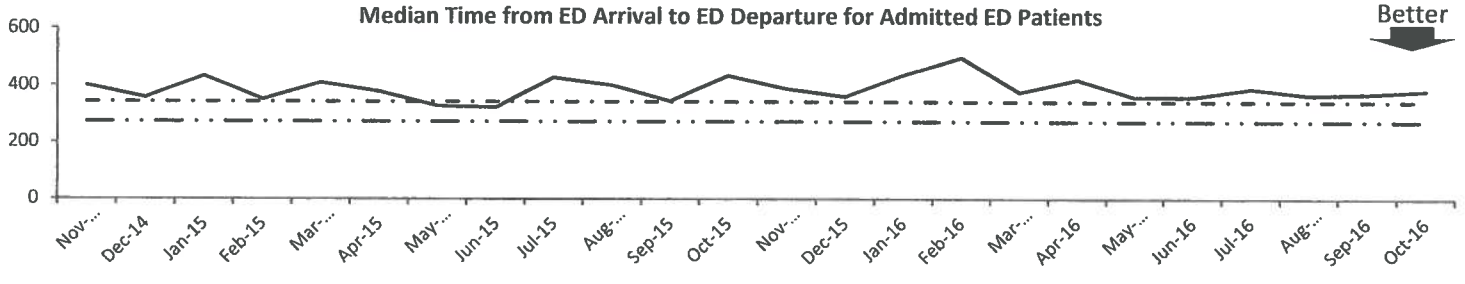
Action Plan

Consistently at 100%



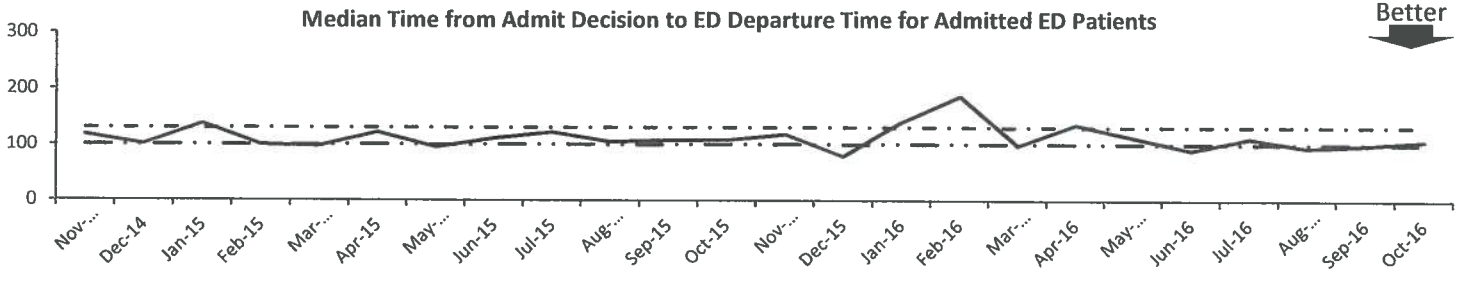
Action Plan

Consistently below national top 10%.



Action Plan

Maintaining results which is consistent with CA mean and National Mean. Continue to hold gains.

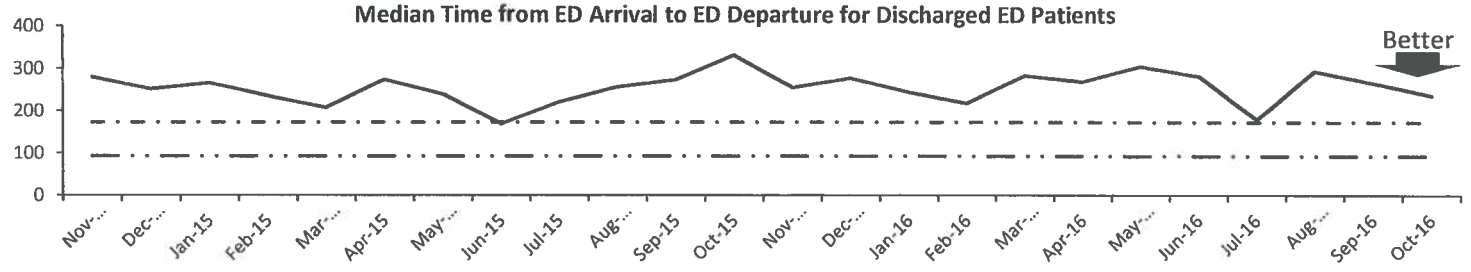


Action Plan

Continue to work on strategies to improve throughput, holding gains that we have achieved.

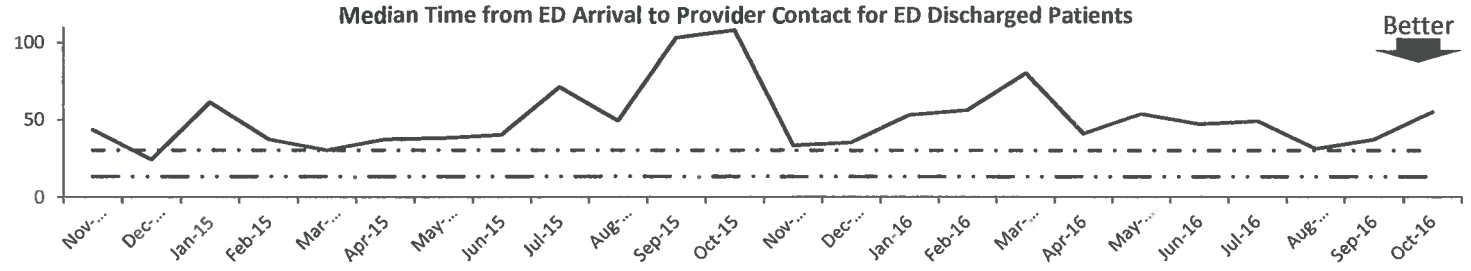
Core Measures

TCMC Rate ····· Mean — · — · CA Mean — · — · — TCMC Target



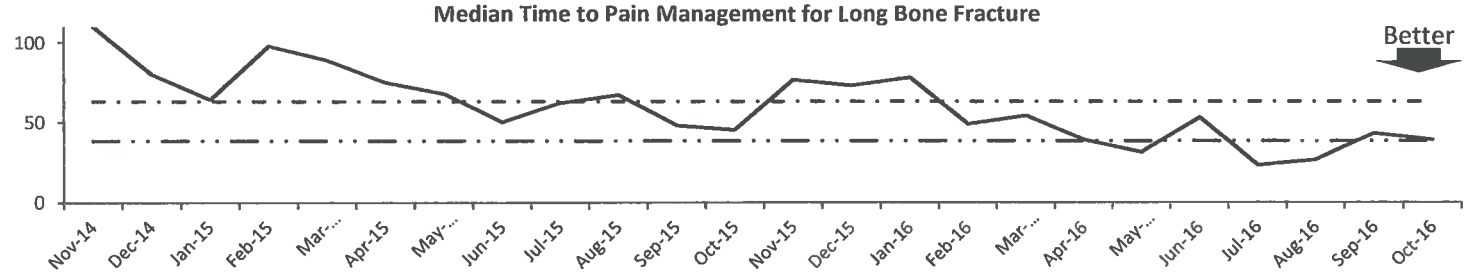
Action Plan

Continue to work on strategies to improve throughput. Piloted ZOOMER RN to assist with quicker discharges.



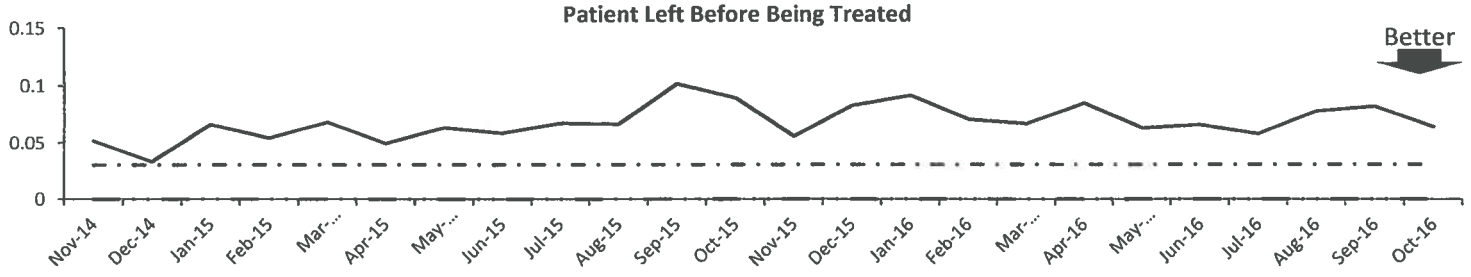
Action Plan

Continued improvement as result of extended Team Triage hours and improved process. Exploring option to extend triage to 24 hrs.



Action Plan

Contiued improvement and at Target goal. Ongoing education on improved use of Triage documentation.



Action Plan

This rate increases when satuation hits the ED, have developed algorithm to predict when expect to see LWBS rate increase to be more proactive.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	28	22	13	25	27	23						138
FY16	49	29	30	30	23	29	23	28	32	27	27	356

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	9	9	5	13	12	11						59
FY16	20	19	15	23	12	13	16	15	15	17	8	188

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	8	11	8	13	12	8						60
FY16	9	10	8	8	13	11	9	13	14	8	8	120

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	18	18	17	14	20	22						109
FY16	16	19	13	4	7	9	15	20	15	13	17	163

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	31	35	29	42	34	29						200
FY16	40	36	37	44	34	33	45	39	38	39	38	473

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	16.5	15.6	15.0	16.2	16.7	16.5						16.1
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5	15.2	14.5	15.3	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	6.8	6.8	6.6	7.0	5.6	6.2						6.5
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6	5.0	6.5	5.5	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	14.8	17.4	17.1	18.6	13.3	17.0						16.4
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3	13.5	16.0	17.1	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	178.6	191.9	181.3	183.9	174	179.5						181.6
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0	186.7	200.7	183.9	191.9

Performance compared to prior year: Better Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	223	239	274	230	197	200						1363
FY16	215	214	252	227	232	220	216	183	209	189	208	2565

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	12	11	12									35
FY16	16	9	19	12	16	10	11	15	15	15	18	168

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	4	4	6									14
FY16	7	3	7	4	5	7	6	6	6	4	2	64

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	10	9	8	7	6	9						49
FY16	7	14	4	6	7	10	2	8	13	12	5	95

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY17	1.68	1.71	1.76	1.72	1.68	1.70						1.71
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63	1.65	1.60	1.66	1.62

Performance compared to prior year: Better Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	51.2	50.2	48.7	50.5	49.6	50.5							50.1	48-52
FY16	46.7	45.7	45.7	45.3	47.0	49.1	51.7	48.9	49.5	50.4	47.4	46.7	46.6	48-52

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY17	78.9	81.6	86.5	88.1	91.6	87.9							85.8	75-100
FY16	83.6	85.8	92.1	88.7	84.0	82.5	83.6	81.1	81.4	81.1	81.1	80.7	86.1	75-100

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$288	$211	$746	$1,118	$414	$317							$3,095	$977
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315	($1,842)	$1,919	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%							1.86%	0.57%
FY16	3.03%	2.20%	0.66%	-0.68%	-2.00%	3.40%	-6.31%	-1.53%	-0.77%	1.13%	1.09%	-6.82%	1.16%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556							$10,726	$8,812
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598	($558)	$9,030	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%							6.44%	5.11%
FY16	7.20%	6.53%	4.90%	3.65%	2.50%	7.58%	-2.10%	2.97%	3.56%	5.22%	5.55%	-2.07%	5.45%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY17	6.04	5.84	5.74	5.85	6.43	6.16							6.01	6.04
FY16	6.13	6.05	5.91	5.98	6.11	6.01	5.77	5.43	6.07	5.86	6.09	5.99	6.03	

TCHD Fixed Charge Coverage Covenant Calculation

	TTM Jul	TTM Aug	TTM Sep	TTM Oct	TTM Nov	TTM Dec	TTM Jan	TTM Feb	TTM Mar	TTM Apr	TTM May	TTM Jun	Covenant	
FY17	1.37	1.37	1.37	1.59	1.73	1.50							1.10	
FY16	1.88	1.96	2.15	2.05	1.85	1.92	1.87	1.73	1.70	1.82	1.63	1.47	1.10	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9							
FY16	$30.7	$33.4	$36.1	$35.7	$31.8	$28.0	$26.3	$27.5	$24.8	$28.0	$37.6	$31.7	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Construction Report
As of December 2016

Project	FOP/Board Approval Date	% of Design Complete	Construction Start or Estimated Construction Start Date	Estimated Construction Completion Date**	% of Construction Complete	Total Budget	Actual Expenditures *	Remaining Budget	Status / Comments
Campus MOB Improvements	February-16	100%	February-16	January-17	99%	$ 969,723.00	$ 455,205.49	$ 514,517.51	Road restriping is the only work remaining. Just waiting for the rain to pass and asphalt to dryout before striping can be completed.
L&D and Mother Baby Renovation	December-16	100%	January-17	July-17	0%	$ 1,191,590.00	$ -	$ 1,191,590.00	Contracts Review.
Rebuild of Men's & Women's ADA Shower Stalls to Code at the Wellness Center	June-16	100%	December-16	January-17	20%	$ 59,945.00	$ 24,997.83	$ 34,947.17	Men's Locker Room demolition is complete.
Total Construction Projects						**$ 2,221,258.00**	**$ 480,203.32**	**$ 1,741,054.68**	

* "Actual Expenditures" excludes capitalized interest.

** Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

Building Operating Leases

Month Ending December 31, 2016

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.85	(a)	10,142.48	2/1/2015	10/31/18	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.56	(a)	19,672.00	2/1/2015	10/31/18	**PCP Clinic - Vista** 1926 Via Centre Drive, Ste A Vista, CA
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,265.25	12/01/15	12/31/20	**PCP Clinic** 2375 Melrose Dr. Vista Vista, CA 92081
GCO 3621 Vista Way Oceanside, CA 92056 #V81473	1,583	$1.92	(a)	3,398.15	01/01/13	12/31/16	**Performance Improvement** 3927 Waring Road, Ste.D Oceanside, Ca 92056
Investors Property Mgmt. Group c/o Levitt Family Trust 2181 El Camino Real, Ste. 206 Oceanside, Ca 92054 V#81028	5,214	$1.86	(a)	10,030.49	09/01/12	08/31/17	**OP Physical Therapy** **OP OT & OP Speech Therapy** 2124 E. El Camino Real, Ste.100 Oceanside, Ca 92054
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	7,247	$1.37	(a)	10,101.01	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	4,760	$4.00	(a)	25,580.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Ridgeway/Bradford CA LP DBA: Vista Town Center PO Box 19068 Irvine, CA 92663 V#81503	3,307	$2.11	(a)	4,984.83	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	6,123	$1.37		7,931.71	12/19/11	12/18/16	**Vacant Medical Office Building** 4120 Waring Rd Oceanside, Ca 92056
Tri City Real Estate Holding & Management Company, LLC 4002 Vista Way Oceanside, Ca 92056	4,295	$3.13		12,393.51	01/01/12	12/31/16	**Vacant Bank Building Property** 4000 Vista Way Oceanside, Ca 92056
Tri City Wellness, LLC 6250 El Camino Real Carlsbad, CA 92009 V#80388	Approx 87,000	$4.08	(a)	246,428.00	07/01/13	06/30/28	**Wellness Center** 6250 El Camino Real Carlsbad, CA 92009
Total				**$359,927.43**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending 12/31/16

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7086	CHEMOTHERAPY BIOTHERAPHY CONFERENCE	120116	103.00	13439	ESTELA TERESA BRAGA
8390	340B COALITION CONFERENCE	113016	799.00	80052	LAURA BALL
8390	340B COALITION CONFERENCE	120116	799.00	80052	TORI HONG
8610	PRIME DATA SUMMIT	LS0124	120.00	80275	STEVE DIETLIN
8610	CERNER CONFERENCE	120716	1,033.76	80739	SCOTT LIVINGSTONE
8614	ACHE LEARNING-UNDERSTANDING MACRA	120216	165.00	77376	JEREMY RAIMO
8700	HPCA ACADEMY	121916	231.36	71807	COLLEEN M THOMPSON
8723	CA-NV ACHSA CONFERENCE	101116	285.00	78664	TJ GRUNNAN RN
8740	NEONATAL CARE	120816	165.00	78614	MARINNEE CHOMPA
8740	ACLS-PALS COURSE	120116	200.00	82315	COLIN HURLOW PAONESSA
8740	CERNER CONFERENCE	112116	1,357.65	67036	KATHY TOPP

**This report shows payments and/or reimbursements to employees and Board Members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.