TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
July 27, 2017 – 1:30 o'clock p.m.
Assembly Room 1 - 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 (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		
	d. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 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
	e. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) (4 Matters)		
	f. Approval of prior Closed Session Minutes		
	g. Conference with Legal Counsel – Existing Litigation (Authority: Government Code, Section 54956.9(d)1, (d)4 (1) 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	Community Update – None	--	--
13	Report from TCHD Auxiliary – Mary Gleisberg, President	5 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Acting Chief Financial Officer	10 min.	Standard
16	New Business		
	a. Consideration to approve Resolution No. 788, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing a Conflict of Interest Policy Covering Design-Build Projects	10 min.	General Counsel
17	Old Business		
	a. Consideration to Approve Resolution No. 787, A Resolution of Application for Proposed Annexation of LAFCO-Recommended Unserved Areas (South Carlsbad and Vista) – *(handout)*	10 min.	General Counsel
	b. Update on CVRA Districting Consultant	5 min.	General Counsel
18	Chief of Staff a. Consideration of July 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Staff as recommended by the Medical Executive Committee on July 24, 2017 b. Consideration of Privilege Cards	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	1) NP – Cardiology 2) PA – Cardiology 3) NP – OBGYN 4) NP – Pediatrics 5) NP – Interventional Radiology 6) NP - Neonatal		
19	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 July, 2017)* **C. Community Healthcare Alliance Committee** Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)* **D. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) **Administrative Policies & Procedures:** a. 8610-263 – Cash Elective Procedures 2) Approval of an agreement with Dr. Cary Mells, Medical Staff Leadership Agreement for Chair of the Physician Well-Being Committee for a term of 24 months, beginning August 1, 2017 through July 31, 2019, not to exceed a total of $36,000 per year and a total cost for the term of $72,000. 3) Approval of a renewal of an agreement with Dr. Marcus Contardo, Chair of the Medical Staff Professional Behavior Committee for a term of 12 months beginning July 1, 2017 through June 30, 2018, a minimum of 30 hours per month or 360 hours annually, for an annual cost of $60,000 and a total cost for the term of $60,000.	5 min.	Standard HR Comm. Emp. Fid. Subcomm. CHAC Comm. FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	4) Approval of an agreement with Dr. Victor Souza, Chief of Staff, for a term of 23 months, beginning August 1, 2017 through June 30, 2019, for a TCHD stipend of $5,950, $71,400 annually, and $136,850 for 23 months; plus an educational allowance up to $10,000 for a total not to exceed $146,850 for the term, paid by TCHD. 5) Approval of a renewal of an agreement with Dr. Mohammad Pashmforoush to the currently existing ED On-Call Coverage Panel for Cardiology for a term of 12 months, beginning, July 1, 2017 through June 30, 2018. 6) Approval of an agreement with Dr. Henry Showah to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 through June 30, 2019. 7) Approval of an agreement with McCoy Design & Construction for $95,025, and the purchase of equipment to replace the lights in operating room #3, for a total expected project cost of $445,379.63. 8) Approval of the formation of an Institute for Clinical Excellence, LLC; TCMC membership in and purchase of membership units, and approval of a co-management agreement with the LLC for a term of 34 months, beginning September 1, 2017 through June 30, 2020, for an annual cost of $750,000 and a total cost for the term of $2,125,000.		
E.	**Professional Affairs Committee** Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* 1) **Patient Care Services** a) ALARIS System Data Set Transfer Procedure b) Black Box Warnings; Drugs With Policy c) Management of ECG Strips d) Medication Administration Policy e) Patient and Family Education Policy f) Patient Rights and Responsibilities g) Program Flexibility h) Referrals to Social Services for Psychosocial Assessment Policy i) Therapeutic Anticoagulation Management Policy j) Vaccination Administration k) Vaccine, Reporting Adverse Events Policy l) Vasc Band Hemostat: Radial Artery Compression Device m) Wasting Narcotics , Documentation in the Pyxis Machine 2) **Administrative Policies and Procedures** a) Assault and Battery Reporting Process b) Assault Victims/ Domestic Violence Reporting		PAC

	Agenda Item	Time Allotted	Requestor

Requirements
c) Consent for Photograph Videotape
d) Handling of Pharmaceutical Waste, Expired Medications
e) Reporting Suspected Child Abuse/ Neglect
f) Reporting Suspected Dependent Adult/ Elder Abuse/ Neglect

3) **Unit Specific – Infection Control**
a) Epidemiologic Investigation of a Suspected Outbreak
b) Hand Hygiene
c) Management of Patients with AIDS

4) **Unit Specific – Medical Staff**

a) Credentialing Criteria, Cardiac Rehab (Outpatient)
b) Credentialing of Emergency Medicine Physicians for Emergency Ultrasounds
c) Criteria for Granting Moderate and Deep Sedation/ Analgesia Privileges to Non-Anesthesiologists
d) Neonatal Narcotic Withdrawal/Abstinence Syndrome, Pharmacological Treatment
e) Peer Review Process: OPPE and FPPE
f) Supervision of Residents in Emergency Medicine

5) **Unit Specific - NICU**

a) Formula, Preparation and Storage of

6) **Unit Specific – Outpatient Behavioral Health**

a) Appointment of Representative Form
b) Daily Schedule
c) Department Safety
d) Downtime procedures
e) Emergency Evacuation
f) Exchange and Replacement of Medication
g) Financial Assessment
h) Fire Safety
i) Food Service Procedures
j) Inclement Weather and Critical Incident Policy
k) Orientation of New Patients
l) Pastoral Care
m) Practicum Student Placement
n) Staff Meetings
o) Staffing Levels

7) **Unit Specific - Outpatient Infusion Center**

a) Age-Specific Guidelines
b) Data Management
c) Diagnostic Tests
d) Disseminating medical Information
e) Environment of Care
f) History and Physical
g) Medical Equipment Maintenance
h) Medical Record Review
i) Patient Instructions

	Agenda Item	Time Allotted	Requestor
	j) Patient Record Content k) Registration of Patients l) Scheduling and Receiving Patients m) Scope of Services n) Staffing Plan o) Standards of Care p) Department Specific Orientation **8) <u>Unit Specific - Pharmacy</u>** a) Automatic IV to Oral Conversion b) Pharmaceutical Representatives **9) <u>Unit Specific – Pulmonary</u>** a) Authorization to Perform (Respiratory Care Students) b) Procedural Triage **10) <u>Unit Specific – Surgical Services</u>** a) Cell Saver Set-Up, Use and Monitoring b) Visitors in the OR Policy **11) <u>Unit Specific – Women & Newborn</u>** a) Infant Transport Intra-facility b) Standards of Care : Intrapartum **12) <u>Pre-Printed Orders</u>** a) Central Venous Access Device Flushes b) Outpatient Extracorporeal Shock Wave Lithotripsy **13)** Approval of Clinical Contracts **F. Governance & Legislative Committee** Director Dagostino, Committee Chair Open Community Seats - 1 *(No meeting held in July, 2017)* **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes.)* (2) Minutes – Approval of: a) Regular Board of Directors Meeting – June 29, 2017 b) Special Board of Directors Meeting – June 22, 2017 (3) Meetings and Conferences – NONE (4) Dues and Memberships - a) ACHD Membership - $25,000		Audit, Comp. & Ethics Comm. Standard
20	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
21	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – Included (c) Lease Report – (June, 2017) (d) Reimbursement Disclosure Report – (June, 2017)	0-5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(d) Reimbursement Disclosure Report – (June, 2017) (e) Seminar/Conference Reports		
22	Legislative Update	5 min.	Standard
23	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
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2 hours/ 15 min.	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

RESOLUTION NO. 788

A RESOLUTION OF THE TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS ESTABLISHING A CONFLICT OF INTEREST POLICY COVERINGN DESIGN-BUILD PROJECTS

WHEREAS, the Tri City Healthcare District ("District") has partnered with the City of Oceanside ("City") pursuant to a Joint Powers Agreement dated August 24, 2016, to utilize the design-build project delivery method for certain statutorily designated projects, including, but not necessarily limited to, the District's planned medical center campus development, in accordance with Public Contract Code section 22160 *et seq.*; and

WHEREAS, Section 22162(c) of the Public Contract Code requires the District to adopt a standard organizational conflict-of-interest policy applicable to its design-build projects as a condition of utilizing the design-build project delivery method; and

WHEREAS, the District desires to adopt an organizational conflict-of- interest policy applicable to its design-build projects in compliance with Public Contract Code section 22162(c).

NOW, THEREFORE, THE BOARD OF DIRECTORS OF THE TRI CITY HEALTHCARE DISTRICT, DOES HEREBY RESOLVE, DETERMINE, FIND AND ORDER AS FOLLOWS:

Section 1. Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2. Conflict-of-Interest Policy. In accordance with Public Contract Code section 22162(c), the District hereby adopts the "Tri City Healthcare District Conflict-of-Interest Policy Covering Design-Build Projects" attached hereto as Exhibit A and incorporated herein by this reference.

Section 3. Effective Date. This Resolution shall take effect upon its adoption.

ADOPTED, PASSED AND APPROVED this _____ day of July, 2017, at a regular meeting of the Board of Directors, at which a quorum was present and acting throughout, at Oceanside, California, by the following vote:

AYES:
NOES:
ABSTAIN/ABSENT:

By:_____
Vice Chair, Board of Directors

ATTEST:

By:_____
Secretary, Board of Directors

Exhibit A

TRI-CITY HEALTHCARE DISTRICT
CONFLICT-OF-INTEREST POLICY COVERING DESIGN-BUILD PROJECTS

The purpose of this document is to clarify the Tri-City Healthcare District's ("District") position on potential conflicts-of-interest that may arise when consultants or contractors (collectively, "Proposer") perform work for the District relating to potential design-build projects in accordance with Public Contract Code section 22162.

Organizational conflicts-of-interest can occur when, because of existing or planned activities or because of relationships with other entities, a Proposer is unable or potentially unable to render impartial assistance or advise the District; a Proposer's objectivity in performing the contract work is or might be otherwise impaired; or a Proposer has an unfair competitive advantage.

The policies and guidelines concerning the organizational conflicts-of-interest found herein will be specified or referenced in the design-build Request for Qualifications/Prequalification ("RFQ") and Request for Proposal ("RFP") documents as well as any contract for the engineering/design services, inspection, or technical support in the administration of the design- build projects.

Resolution of conflict-of-interest issues is ultimately at the sole discretion of the District. The District reserves the right to cancel or amend the resulting contract(s) if a successful Proposer failed to disclose a potential conflict, which it knew or should have known about, or if a Proposer provided information in response to an inquiry from the District that is false or misleading.

After award, conflict-of-interest guidelines and policies shall continue to be monitored and enforced. If an organizational conflict-of-interest is discovered after award, the Proposer will make an immediate and full written disclosure to the District that includes a description of the action that the Proposer has taken or proposes to take to avoid or mitigate such conflicts. If an organizational conflict-of-interest is determined to exist and the Proposer was aware of an organizational conflict-of-interest prior to award of the contract and did not disclose the conflict- of-interest, the District may terminate the contract with the Proposer for material breach. If the Proposer is terminated, the District assumes no obligations, responsibilities and liabilities to reimburse all or part of the costs incurred or alleged to have been incurred by the Proposer.

APPROACH

The following approach to conflict-of-interest will apply to District procurements relating to design-build projects undertaken pursuant to Public Contract Code section 22160 et seq:

I. A potential Proposer will not be allowed to participate as a design-build entity or to join a design-build team if, without limitation, any of the following is true:

   A. The Proposer (and/or its sub-consultants or subcontractors) is currently under contract with the District to provide general engineering, contracting, or design consulting for the design-build project at issue.

   B. The Proposer has assisted the District in managing or developing or is assisting in the management and/or development of the design-build RFQ or RFP, including

the preparation of the RFQ or RFP language or evaluation criteria.

C. The Proposer has conducted preliminary design services for the development of the design-build RFQ or RFP such as geometric layouts, bridge-type selection, preliminary bridge design, etc.

D. The Proposer performed design work related to the design-build project for other project stakeholders.

E. The Proposer has performed work on a previous contract that specifically excludes them from participating as a design-build entity or joining a design-build team on the design-build project, such as the bridging architect or Project construction manager.

F. The Proposer is under contract with any other entity or stakeholder to perform oversight on the design-build project.

G. The Proposer has obtained any material advice from, or discussed any material aspect relating to the project or procurement of the project with any person or entity with an organizational conflict-of-interest, including, but not limited to, the consultants and contractors of any entity who has provided technical support to the District for the design-build project.

II. Proposers who may have potential conflicts-of-interest in relation to the design-build project and wish to participate as a Proposer or join a design-build team must:

A. Conform to all applicable federal and state conflict-of-interest rules and regulations including, without limitation, the California Political Reform Act, California Government Code Section 1090, the federal Copeland "Anti- Kickback" Act and federal conflict-of-interest rules set forth in the federal funding agency's administrative grant and cooperative agreement regulations. Federal conflict-of-interest rules and regulations shall only apply where the design-build project receives federal funding. If such funding is used for the project in question the applicable federal funding source and applicable conflict rules will be disclosed in the RFP and contract documents issued for the project.

B. Disclose all relevant facts relating to past, present or planned interest(s) of the Proposer's team (including the Proposer, Proposer's proposed consultants, contractors, sub-consultants and/or subcontractors and their respective chief executives, directors and key personnel) which may result, or could be viewed as an organizational conflict-of-interest in connection with any design-build procurement, including present or planned contractual or employment relationships with any current employee of the District.

C. Disclose in the response documents to a design-build RFQ and RFP, all of the work performed in relation to the design-build project being procured under the RFQ and RFP.

D. Provide all records of the work performed in relation to the design-build project to the District so that all information can be evaluated and made available to all potential design-build teams, if necessary.

E. Ensure that the Proposer's contract with any entity to perform services related to the design build project has expired or has been terminated.

Upon review of the information provided above, the Chief Executive Officer will determine, in his or her sole discretion, if the Proposer has an organizational conflict-of-interest. Decisions of the Chief Executive Officer regarding organizational conflicts-of-interest may be appealed to the District's Board of Directors. The decision of the District's Board of Directors shall be final with respect to the disposition of the organizational conflict-of-interest and non-appealable.

III. For other potential conflicts-of-interest not mentioned above (e.g. employee changing companies, merger/acquisitions of firms, property ownership, business arrangements, financial interest), Proposers shall disclose and address any conflicts-of-interest or potential conflicts-of-interest when participating as a design-build entity or joining a design-build team. The District will then determine if an organizational conflict-of-interest exists.

IV. The successful Proposer or firms affiliated with the successful Proposer are prohibited from competing on any agreement to provide construction inspection services for the design-build project. An affiliated firm is one, which is subject to the control of the same persons, through joint ownership or otherwise. No sub-consultants who provided design services in connection with the design-build project shall be eligible to compete for any agreement to provide construction inspection services for the design-build project.

Notes – The foregoing is provided by way of example, and shall not constitute a limitation on the obligations of the Proposer in relation to organizational conflicts-of-interest.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
July 12, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/28/2017 – 6/30/2019)

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 7/28/2017 through 6/30/2019:

- **CHAUHAN, Aakash M.D. / Orthopedic Surgery FELLOW – Assist ONLY (Orthopedic Specialist N. Co)**
- **HWANG, Janice M.D. / Tele-radiology (StatRad)**
- **LEE, Yu-Po M.D. / Orthopedic Surgery (Orthopedic Specialists of North County)**
- **ROSS, Richard M.D. / Emergency Medicine (TCEMG)**
- **WANG, Joyce M.D. / Emergency Medicine (TCEMG)**
- **ZHAO, Zhong M.D. / Internal Medicine (Coastal Hospitalists Medical Assoc.)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
July 12, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 8/01/2017 –7/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/01/2017 through 7/31/2019, 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:

- **ADHANOM, Teamrat, MD/Internal Medicine/Active**
- **COHEN, David, MD/Cardiology/Provisional**
- **CORONA, Frank, MD/Pulmonary/Active**
- **CURRAN, Perrin, MD/Internal Medicine/Refer and Follow**
- **DEMBITSKY, Zachary, MD/Emergency Medicine/Provisional**
- **DESADIER, Laura, DO/Neurology/Provisional**
- **FOLKERTH, Theodore, MD/Cardiothoracic Surgery/Active**
- **GUTIERREZ, Miguel, MD/Emergency Medicine/Active**
- **HIGGINS, Steven, MD/Cardiology/Active**
- **HOBSON, Margaret, MD/Dermatology/Provisional**
- **KAO, Jerry, MD/Pathology - Anatomic/Active**
- **KASED, Norbert, MD/Radiation Oncology/Active**
- **KOCH, Richard, MD/Emergency Medicine/Active**
- **LEONARD, Lisa, MD/Obstetrics and Gynecology/Provisional**
- **LI, Xiangli, MD/Internal Medicine/Provisional**
- **MA, Gene, MD/Emergency Medicine/Active**
- **MARQUART, Elizabeth, MD/Emergency Medicine/Active**
- **OH, Irene, MD/Neurology/Active**

Attachment B

- PARK, Sue Ann, MD/Pediatrics/Active
- PREGERSON, David, MD/Emergency Medicine/Active
- REISMAN, Bruce, MD/Otolaryngology/Active
- SCHEINBERG, Robert, MD/Dermatology/Refer and Follow
- SHIN, Heamin, DPM/Podiatric Surgery/Active
- STEWART, Ryan, MD/Internal Medicine/Refer and Follow
- STUPIN, Jeremy, MD/Diagnostic Radiology/Active
- VILCHIS, Caroline, MD/Urology/Active
- WACLAWSKI, Richard, MD/Anesthesiology/Provisional

RESIGNATIONS: (Effective date 7/31/2017 unless otherwise noted)

Automatic:

- MAZUR, Paul, MD/Cardiothoracic Surgery

Voluntary:

- DENSERT, Ruchira, MD/Psychiatry
- GARG, Aruna, MD/Pediatrics
- HAZELWOOD, Kyle, MD/Orthopedics
- HOLLAND, William, MD/Orthopedic Surgery
- HUDSON, Henry, MD/Ophthalmology
- KERNS, Garrett, DO/Orthopedics
- MCQUEEN, Peter, MD/Orthopedics
- WEST, Justin, MD/Orthopedics
- WILKE, Lindsey, DPM/Podiatric Surgery
- ZHONG, Yan, MD/Internal Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
July 12, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/28/17, unless otherwise specified)

- COHEN, David M.D. — Cardiology
- CONANT, Reid M.D. — Emergency Medicine
- DILLMAN, Ariana M.D. — Emergency Medicine
- EL-SHERIEF, Karim M.D. — Cardiology
- GUTIERREZ, Miguel M.D. — Emergency Medicine
- KAYAL, Anas M.D. — Nephrology
- KOCH, Richard M.D. — Emergency Medicine
- LAU, Kenneth M.D. — Anesthesiology
- LOZANO, Jesus M.D. — Anesthesiology
- LUDEMAN, Lori M.D. — Emergency Medicine
- MARZAN, Yolanda M.D. — Anesthesiology
- MARQUART, Elizabeth M.D. — Emergency Medicine
- MATTHEWS, Oscar M.D. — Cardiology
- MCGRAW, Charles M.D. — Radiology
- MCWHIRTER, Rober M.D. — Emergency Medicine
- NOUD, Michael M.D. — Radiology
- OH, Irene M.D. — Neurology
- ONAITIS, Mark M.D. — Emergency Medicine
- PERRIZO, Nathan D.O. — Internal Medicine
- PREGERSON, David M.D. — Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
July 12, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/28/17, unless otherwise specified)

- **COHEN, David M.D.** — **Cardiology**
  Release from Proctoring: Admission, Consultation, Perform History & Physical, Moderate Sedation, Fluoroscopy and Permanent Pacemakers/ICD

- **CONANT, Reid M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **DILLMAN, Ariana M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **EL-SHERIEF, Karim M.D.** — **Cardiology**
  Release from Proctoring: Insertion of Temporary Transvenous Cardiac Pacemaker & Elective Cardioversion

- **GUTIERREZ, Miguel M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **KAYAL, Anas M.D.** — **Nephrology**
  Release from Proctoring: Consultation, Nephrology, including via telemedicine (F), History and Physical Examination, Nephrology, including via telemedicine (F); Hemodialysis; Peritoneal dialysis

- **KOCH, Richard M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **LAU, Kenneth M.D.** — **Anesthesiology**
  Release from Proctoring: Regional Anesthesia

- **LOZANO, Jesus M.D.** — **Anesthesiology**
  Release from Proctoring: Invasive Monitoring

- **LUDEMAN, Lori M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **MARZAN, Yolanda M.D.** — **Anesthesiology**
  Release from Proctoring: Regional Anesthesia

- **MARQUART, Elizabeth M.D.** — **Emergency Medicine**
  Release from Proctoring: Ultrasound guidance for approved procedures

- **MATTHEWS, Oscar M.D.** — **Cardiology**
  Release from Proctoring: Insertion of Temporary Transvenous Cardiac Pacemaker

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
July 12, 2017

Attachment C

- **MCGRAW, Charles M.D.**
  Release from Proctoring:
  Radiology
  General Diagnostic Radiology and Fluoroscopy and Genito-Urinary Intervention

- **MCWHIRTER, Rober M.D.**
  Release from Proctoring:
  Emergency Medicine
  Deep Sedation

- **NOUD, Michael M.D.**
  Release from Proctoring:
  Radiology
  Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders

- **OH, Irene M.D.**
  Release from Proctoring:
  Neurology
  Admit & Perform History & Physical

- **ONAITIS, Mark M.D.**
  Release from Proctoring:
  Emergency Medicine
  Admit, Consultation, Perform History & Physical, Robotic Surgery (da Vinci) – Core Privileges, Xi Robotic Surgery

- **PERRIZO, Nathan D.O.**
  Release from Proctoring:
  Internal Medicine
  Physical Medicine and Rehabilitation (Physiatry) Consultaiton

- **PREGERSON, David M.D.**
  Release from Proctoring:
  Emergency Medicine
  Ultrasound guidance for approved procedures

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
July 14, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

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 January 31, 2018 would result in these privileges automatically relinquishing.

- AHUMADA, Alejandro, AuD — Allied Health Professional
- BUCKLEY, Alicia, Ortho Tech — Allied Health Professional
- CARLTON, Vivian W., PAC — Allied Health Professional
- CHANDLER, Brie A, PAC — Allied Health Professional
- CHASE, Nicole PAC — Allied Health Professional
- COWAN, John, W., PAC — Allied Health Professional
- ELAMPARO, Kaye L., NP — Allied Health Professional
- HAMMONDS, Tommy PAC — Allied Health Professional
- HERMANN, Linda, PAC — Allied Health Professional
- HUANG, Stephanie, K., PAC — Allied Health Professional
- LAM, Christina, NP — Allied Health Professional
- MARTINEZ, Melinda PAC — Allied Health Professional
- RICE, William M., PAC — Allied Health Professional
- SON, Alicia, PAC — Allied Health Professional
- WALTERS, Janet RN, RNFA — Allied Health Professional

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 7/28/2017, unless otherwise specified)

The following practitioners requested to relinquish the following privileges

- **TAYLOR, Phyllis NP** — **Allied Health Professional**

ADDITIONAL EQUIPMENT USE REQUEST

The following practitioners have previously met the initial criteria Assist in Robotic Surgery and have turned in the certificate to Assist with the utilization of the Xi Robotics Equipment:

- **FAZZINO, Dolores RNFA** — **Allied Health Professional**
- **COWAN, John PAC** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
July 14, 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 07/28/2017 through 06/30/2019:

- **MURPHY, Kayla CNM / Allied Health Professional (North County Health Svcs.)**
- **SCHILLINGER, Stephan PAC / Allied Health Professional (TeamHealth)**
- **WEICHERT, Rachel AuD / Allied Health Professional (Neurosound Inc.)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
July 14, 2017

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 8/1/2017 – 7/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/1/2017 through 7/31/2019, 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:

- **ALLEN, Danielle, AuD/Allied Health Professional**
- **HUEFTLE, Rachael, NP/Allied Health Professional**
- **JOHNSON, Mark, PAC/Allied Health Professional**
- **KIMBER, James, PAC/Allied Health Professional**

RESIGNATIONS:

Automatic

- **PREISER, Kristin, NP/Allied Health Professional**

Voluntary

- **LEWIS, Chris, PA/Allied Health Professional**
- **NAVARO, Katherine, PA/Allied Health Professional**
- **SAKHAROV, Aleksandr, PA/Allied Health Professional**
- **SPRUEL, Candyce, MFT/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE CREDENTIALS REPORT – Part 3 of 3
July 14, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 7/28/17, unless otherwise specified)

• ALLEN, Matthew PA-C	Emergency Medicine
• CARLTON, Vivian PA-C	Emergency Medicine
• CHANDLER, Brie PA-C	Emergency Medicine
• CHASE, Nicole PA-C	Emergency Medicine
• GARBACZEWSKI, Stephanie PA-C	Emergency Medicine
• HAMILTON, James PA-C	Orthopedic Surgery
• HERMANN, Linda PA-C	Emergency Medicine
• MARTINEZ, Melina PA-C	Emergency Medicine
• MCDONALD, April NP	Neonatology
• OLSON, Lindsey PA-C	Emergency Medicine
• RICE, William PA-C	Emergency Medicine
• SCOTT, Katie PA-C	Emergency Medicine
• OLSON, Lindsey PA-C	Emergency Medicine

Tri-City Medical Center

Delineation of Privileges

NP - Cardiology ~~5/13~~

Provider Name:

Request	Privilege	Action MSO Use Only

Service Authorization for Nurse Practitioner - Cardiology

Initial: ~~Refer to AHP rules and regulations for credentialing requirements~~

1. Education and training:
   a) Master's degree in Nursing from an accredited college or university; AND
   b) Completion of an approved Adult, Child, or Family Nurse Practitioner program.
2. Licenses and Certification:
   a) Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   b) Currently certified by the State of California as a Nurse Practitioner;
   c) Possession of a California State-issued medication Furnishing Number;
   d) Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   e) ACLS in accordance with the specialty requirement.
   f) CNOR Certification if assisting in surgery.

Proctoring: First six (6) total cases from this privilege card

___ Collaborate in the diagnosis, evaluation and management of the patient

___ Emergency cardiac treatment

___ Furnish medications following the Drugs and Devices protocol as described in the standardized procedures

___ Order or transmit an order for x-ray, other studies, ECGs, cardiac stress testing, echocardiography, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services

___ Perform history and physical examination

___ ~~Cardiac stress testing, under supervision of a cardiologist~~
~~Initial: Documentation of twelve (12) cases~~
~~Proctoring: Two (2) cases~~
~~Reappointment: Fifty (50) cases~~

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

NP - Cardiology ~~5/13~~

Provider Name:

Request	Privilege	Action MSO Use Only

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.

Approval:

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

PA - Cardiology ~~5/13~~

Provider Name:

Request	Privilege	Action MSO Use Only

Service Authorization for Physician Assistant (PA) - Cardiology

Initial: Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.
Proctoring: Six (6) cases, at least two (2) cases must be Cardiac Stress Testing

___ Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans, record and present pertinent data in a manner meaningful to the physician. ___

___ Order or transmit an order for x-ray, other studies, therapeutic diets, physical/rehab therapy, occupational/speech therapy, respiratory therapy, and nursing services. ___

___ Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures. ___

___ Recognize and evaluate situations that call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient. ___

___ Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases. ___

___ Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home. ___

___ Initiate and facilitate the referral of patients to the appropriate health facilities, agencies and resources of the community. ___

___ Order and administer medications. A physician assistant may not administer, provide or transmit a prescription for controlled substances in schedules II through V without patient-specific authority by a supervising physician. A physician assistant may not order chemotherapy agents. ___

Initial: Current, valid DEA registration issued by the United States Drug Enforcement Administration

___ ~~Cardiac stress testing, under supervision of a cardiologist~~
~~Initial: Documentation of twelve (12) cases~~
~~Proctoring: Two (2) cases~~
~~Reappointment: Fifty (50) cases~~ ___

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

PA - Cardiology ~~5/13~~

Provider Name:

Request	Privilege	Action MSO Use Only

Division/Department Signature

Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:

As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

Print Name of Sponsoring Physician

Sponsoring Physician Signature

Date

Tri-City Medical Center

Delineation of Privileges

NP – OB/GYN

Provider Name:

Request	Privilege	Action MSO Use Only

Initial Criteria:
The nurse practitioners must have the following:
1. Valid, California Registered Nurse license;
2. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;
3. Successful completion of a Board of Registered Nursing approved Nurse Practitioner program;
4. Successful completion of the Family, Geriatric, or Adult nurse practitioner Credentialing Examination or equivalent national specialty certification;
5. Furnishing number from the State of California Board of Registered Nursing;
6. Valid, current DEA number and BRN approved 3 hour continuing education course

___ First assist at c-section and hysterectomy (specific tasks of retraction, suction, ligation, clamping, sponging, and cutting sutures) ___
Initial: Documentation of appropriate training/education required
Proctoring: Two (2) Cesarean Section assists

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

Approval:

_____
Division/Department Signature

_____
Date

Tri-City Medical Center

Delineation of Privileges

NP - Pediatrics

Provider Name:

Request	Privilege	Action MSO Use Only

Initial Criteria:
The nurse practitioner must have the following:
1. Possession of a current California Registered Nursing license;
2. Successfully completed a Board of Registered Nursing approved nurse practitioner program;
4. If furnishing drugs and devices, the nurse practitioner must possess a furnishing license;
5. Nurse practitioners wishing to furnish Schedule II through V controlled substances are required to complete a Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate to prescribe Schedule II-V drugs.
6. Work experience - applicant must provide documentation of at lease 24 cases in the past 24 month period showing that they have worked with newborns less then 10 days old.

Please check the box next to the practice prerogatives bundle(s) you wish to request. Please strike through any procedure within your requested bundle that you do not wish torequest.

COGNITIVEPREROGATIVES:

Proctoring Requirements:
A minimum of 6 cases proctored resulting in any combination of H&P.

— Performance of a History & Physical Examination

NP PEDIATRICS CORE PREROGATIVES:

Prerequisite Criteria: Must have (1) current California Registered Nurse License and (2) successfully completed a Board of Registered Nursing approved nurse practitioner program and (3) NP Certification by the State of California Board of Registered Nursing (4) current Furnishing License (5) if wishing to furnish Schedule II through V controlled substances the AHP must complete a Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate to prescribe Schedule II-V drugs.

Initial Criteria: Practitioner must comply with all of the above noted prerequisite criteria and show current competency of 6 cases of any practice prerogatives listed in this bundle. If provider does not have current acute care experience they will be concurrently proctored until they have submitted a total of 8 cases 4 of which need to be an admit/discharge, 2 general care and 2 must show management of Group B Strep (GBS) positives, neonatal jaundice, transient tachypnea of the newborn (TTN) or neonatal hypoglycemia.

Proctoring Requirements: 6 cases

Reappointment Criteria: In order to maintain this practice prerogatives bundle, competency criteria of 6 cases representative of at least 3 prerogatives in this bundle for the previous 2-year period is required.

— Initiate admissions/discharges (all admissions/discharges must be on order of physician) for newborn

— Common nursing functions of health promotion

— General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)

— Initiate daily rounds with or without the physician

— Order or transmit an order for lab, x-ray, or other studies as appropriate

— Furnish medications following the Drugs and Devices protocol as described in the standardized procedures

— Manage and treat acute/episodic illnesses, and chronic conditions

— Recommend diets

Tri-City Medical Center

Delineation of Privileges

NP - Pediatrics

Provider Name:

Request	Privilege	Action MSO Use Only
—	Refer to Specialty Clinics and appropriate health facilities, agencies, and resources in the community when indicated	—
—	Write patient summaries	—

APPLICANT:
I agree to exercise only those privileges specifically granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

Print Applicant Name

Applicant Signature

Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I have reviewed the requested privileges and agree they are appropriate to the capacity in which this Allied Health Professional will function. I further agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

Print Name of Sponsoring Physician

Sponsoring Physician Signature

Date

I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.

Approval:

Division/Department Signature

Date

Tri-City Medical Center

Delineation of Privileges

NP - Interventional Radiology

Provider Name:

Request	Privilege	Action MSO Use Only

Criteria:
The nurse practitioners must have the following:
1. Valid, California Registered Nurse license;
2. Successful completion of a Board of Registered Nursing approved Nurse Practitioner program;
3. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner;
4. Successful completion of the Family, Geriatric, or Adult Nurse Practitioner Credentialing examination or equivalent national specialty certification (preferred);
5. If furnishing drugs and devices, the Nurse Practitioner must possess a furnishing license;
6. Nurse Practitioners wishing to furnish Schedule II controlled substances are required to complete a Board of Registered Nursing approved three (3) hour continuing education course as well as possess a current, valid DEA certificate to prescribe Schedule II-V drugs.

The following privileges may be performed by the Nurse Practitioner in accordance with standardized procedures and protocols.

Proctoring: Ten (10) cases (proctoring for Therapeutic Procedures may be used towards fulfilling this general proctoring requirement.)
Reappointment: Satisfactory evaluation by supervising physician.

—— **General Patient Care Privileges:**

By selecting this privilege, you are requesting the General Patient Care privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Perform history and physical exam

Furnish drugs consistent with the TCMC Formulary and as outlined in the standardized procedures and protocols.

Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication.

General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)

Recommend therapeutic diets and exercise

Provide patient education and counseling

Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the nurse's knowledge and/or skills, or for those conditions that require consultation

—— **Therapeutic Procedures:** A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.

By selecting this privilege, you are requesting the Therapeutic Procedures privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Abscess drainage tube manipulation / resuturing

Central line insertion: jugular line insertion

Proctoring: Three (3) cases

Central line insertion: PICC line insertion

Proctoring: Three (3) cases

Tri-City Medical Center

Delineation of Privileges

NP - Interventional Radiology

Provider Name:

Request	Privilege	Action MSO Use Only
	Chest tube removal	
	Keo feeding tube insertion/nasogastric tube insertion	
	Lumbar puncture	
	Proctoring: Three (3) cases	
	Paracentesis	
	Proctoring: Three (3) cases	
	Peripheral IV line insertion	
	Removal of drains and tubes	
	Removal of tunneled catheter	
	Removal of venous port (Mediport)	
	Subcutaneous local anesthesia	
	Suturing and suture removal	

APPLICANT:
I agree to exercise only those services granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

Print Applicant Name

Applicant Signature

Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

Print Name of Sponsoring Physician

Sponsoring Physician Signature

Date

Approval:

Tri-City Medical Center

Delineation of Privileges

NP - Interventional Radiology

Provider Name:

Request	Privilege	Action MSO Use Only

Division/Department Signature

Date

Tri-City Medical Center

Delineation of Privileges

NP - Neonatal 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

Initial Criteria:
The nurse practitioner must have the following:
1. Possession of a current California Registered Nursing license;
2. Successfully completed a Board of Registered Nursing approved nurse practitioner program;
3. Certification as a nurse practitioner by the California Board of Registered Nursing (Title 16, Article 8, Section 1482, Business and Professions Code);Successful completion of the Neonatal Nurse Practitioner National Certification Examination within one year of initial credentialing;
4. If furnishing drugs and devices, the nurse practitioner must possess a furnishing license;
5. Nurse practitioners wishing to furnish Schedule II through V controlled substances are required to complete a Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate to prescribe Schedule II-V drugs.

Proctoring: Six (6) cases

Pleasechecktheboxnexttothepractice prerogativesbundle(s)youwishtorequest.Pleasestrikethroughanyprocedure within your requested bundle that you do not wish torequest.

COGNITIVEPREROGATIVES:

Proctoring Requirements:
A minimum of 6 cases proctored resulting in any combination of H&P.

___ Performance of a History & Physical Examination

NP NEONATOLOGY CORE PREROGATIVES:

Prerequisite Criteria: Must have (1) current California Registered Nurse License and (2) successfully completed a Board of Registered Nursing approved nurse practitioner program and (3) NP Certification by the State of California Board of Registered Nursing (4) current Furnishing License (5) if wishing to furnish Schedule II through V controlled substances the AHP must complete a Board of Registered Nursing approved 3 hour continuing education course as well as possess a DEA certificate to prescribe Schedule II-V drugs.

Initial Criteria: Practitioner must comply with all of the above noted prerequisite criteria and show current competency of 6 cases of any practice prerogatives listed in this bundle.

Proctoring Requirements: 6 cases

Reappointment Criteria: In order to maintain this practice prerogatives bundle, competency criteria of 6 cases representative of at least 3 prerogatives in this bundle for the previous 2-year period is required.

___ Initiate admissions (all admissions must be on order of physician)

___ Common nursing functions of health promotion

___ General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)

___ Initiate daily rounds with or without the physician

___ Order or transmit an order for lab, x-ray, or other studies as appropriate

___ Furnish medications following the Drugs and Devices protocol as described in the standardized procedures

___ Manage and treat acute/episodic illnesses, and chronic conditions

Tri-City Medical Center
Delineation of Privileges
NP - Neonatal 11/14

Provider Name:

Request	Privilege	Action MSO Use Only
—	Recommend diets	
—	Refer to Specialty Clinics and appropriate health facilities, agencies, and resources in the community when indicated	—
—	Write patient summaries	—

NP NEONATOLOGY
SPECIAL PROCEDURES

Initial Criteria: AHP Practitioner must comply with all of the above noted prerequisite criteria and show current competency of 6 cases of any 3 practice prerogatives listed in this bundle.
The necessity of the procedure will be determined by the NNP in verbal collaboration with the supervising physician.

Proctoring Requirements: 6 cases

Reappointment Criteria: In order to maintain this practice prerogatives bundle,competency criteria of 6 cases representative of
2 for each prerogative in this bundle for the previous 2-year period is required.

Prerequisite Criteria:

1. Must have unrestricted NP Core Practice Prerogatives

—	Endotrachael Intubation	
—	Umbilical Catheter Placement	—
—	Peripheral Arterial Line Placement	—

APPLICANT:
I agree to exercise only those privileges specifically granted to me. I understand that I may not perform any functions within Tri-City Medical Center that are not specifically approved by the appropriate Department/Division and the Interdisciplinary Practice Committee.

Print Applicant Name

Applicant Signature

Date

*Note - Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I have reviewed the requested privileges and agree they are appropriate to the capacity in which this Allied Health Professional will function. I further agree to be held responsible for his/her performance while providing services at Tri-City Medical Center

Tri-City Medical Center

Delineation of Privileges

NP - Neonatal 11/14

Provider Name:

Request	Privilege	Action MSO Use Only

Print Name of Sponsoring Physician

Sponsoring Physician Signature

Date

I certify that I have reviewed and evaluated the applicant's request for clinical privileges and other supporting information, and that the recommendations as noted below have been made with all pertinent factors considered.

Approval:

Division/Department Signature

Date

DRAFT

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
July 11, 2017

Voting Members Present:	Chair Cyril Kellett, Director Leigh Anne Grass, Director Rosemarie Reno, Dr. Hamid Movahhedian, Virginia Carson, Gwen Sanders, Joe Quince, Salvador Pilar, Dr. Martin Nielsen
Non-Voting Members Present:	Kapua Conley, COO; Sharon Schultz, CNE; Scott Livingstone, Interim CCO; Norma Braun, CHRO; Esther Beverly, VP of HR
Others Present:	Jill Byrd, Frances Carbajal
Members Absent:	Steve Dietlin, CEO; Dr. Gene Ma

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 July 11, 2017. Ginny Carson moved and Gwen Sanders 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.		Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the May 9, 2017 meeting. Director Reno moved and Director Grass seconded the motion. The motion was carried unanimously.		Chair Kellett
5. Old Business	None		
6. New Business			

Topic	Discussion	Action Follow-up	Person(s) Responsible
a. Review HR Metrics	Norma Braun, HR SVP presented a detailed year to date metrics analysis which included key statistics like employee turnover percentage rates by department & reason for termination. Recruitment measures were also discussed; time to fill positions, vacancies by month & ongoing HR initiatives to recruit and retain employees.		Norma Braun
b. Review Key Grievance/ ER-LR Data	Mrs. Braun also explained current employee and labor relations data in concert with metrics analysis.		Norma Braun
c. Review Employee Health & Wellness	Jill Byrd, EHS Lead updated the committee on the status of the employee wellness program. Jill discussed incentives, active participant count, successes, challenges and overall program redesign.		Norma Braun
7. 2017 Work Plan	The 2017 Work Plan was reviewed & discussed.		Chair Kellett
8. Committee Communications	Community Member Gwen Sanders expressed interest in bringing Policy 429- Alcohol & Drug Testing forward to the next HRC meeting for discussion.		Chair Kellett
9. Date of next meeting	**August 8, 2017**	Meetings with limited informational topics will be cancelled.	Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 1:21 p.m.		Chair Kellett

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

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
July 20, 2017

MEMBERS PRESENT: CHAC Chair Julie Nygaard, Director Larry Schallock; Dr. Victor Souza, MD; Danielle Pearson, Gigi Gleason, Guy Roney, Linda Ledesma, Marilou de la Rosa Hruby, Mary Lou Clift, Mary Murphy, Rick Robinson, Sandy Tucker.

MEMBERS ABSENT: Director Jim Dagostino, Barbara Perez, Bret Schanzenbach, Carol Herrera, Dung Ngo, Jack Nelson, Mary Donovan, Roma Ferriter, Rosemary Eshelman, Ted Owen, Xiomara Arroyo.

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; Audrey Lopez

NON-VOTING MEMBERS ABSENT: Fernando Sanudo, David Bennett, Chief Marketing Officer; Kapua Conley, COO

OTHERS PRESENT: Gwen Sanders

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The July 20, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:39 pm by Director and CHAC Chair Julie Nygaard.		
Approval Of Meeting Agenda	Sandy Tucker motioned to approve the July 20, 2017 meeting agenda. The motion was seconded by Director Larry Schallock and unanimously approved.		
Public Comments & Announcements	No public comments or announcements were made.		

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU

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Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

July 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Ratification Of Minutes	Gigi Gleason motioned to approve the June 15, 2017 CHAC meeting minutes. The motion was seconded by Sandy Tucker and unanimously approved.		
Presentation: Scott Ashton CEO – Oceanside Chamber of Commerce	CEO Scott Ashton presented information about the Oceanside Chamber of Commerce as follows: ▪ The Chamber recently developed a 3-year strategic plan for Oceanside ▪ The Oceanside Chamber has over 680 members ▪ The Chamber employs 5 full time and 2 part time staff members The mission of the Oceanside Chamber is to "stimulate economic prosperity and foster a vibrant community." The key areas of service include: ▪ Providing Networking Opportunities ▪ Promoting the Community ▪ Business Education ▪ Creating a Strong Local Economy ▪ Representing Business Interests The 2020 Strategic Plan will focus on: ▪ Public Policy ▪ Economic Development ▪ Workforce Development ▪ Neighborhood Business Outreach ▪ Military Outreach ▪ Food Service Industry Support		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

July 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Presentation: Scott Ashton CEO – Oceanside Chamber of Commerce	Scott answered audience questions and the Committee was very happy to hear about the good work the Chamber is providing to the residents of Oceanside.		
CEO Update Steve Dietlin	CEO Steve Dietlin updated the group as follows: ▪ Steve thanked Scott Ashton for his presentation and for the Chamber's support for TCMC's design and build efforts. ▪ Steve noted that TCMC is currently undergoing redistricting efforts along with members of the District. More details will be available as the efforts progress. ▪ A RFQ public meeting was recently held with apx. 75 people in attendance. ▪ TCMC is working with the City of Oceanside regarding all needed processes concerning campus upgrades. ▪ Steve noted that TCMC is looking to grow our cardio program, especially with our new partnership with UCSD and affiliation with the American Heart Association, so that district residents can be helped and educated about quality heart care and preventative measures prior to crisis events. Dr. Souza, Chief of Staff, noted that med staff is very engaged in providing high quality care and will work to do so through anticipated political/insurance changes over the next few years.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

July 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin	Julie Nygaard noted that TCMC is actively engaged in looking at all political issues so that TCMC is better prepared for future health care adjustments.		
Committee Vacancies	Chair Julie Nygaard stated there remains two vacancies on the Committee that need to be filled, however, the Vista District Resident vacancy may have a candidate option. Oceanside is still looking for a District Resident candidate.		
Public Comments	There were no public comments.		
Committee Communications	Audrey Lopez informed the group that the Grandparents Raising Grandchildren "My Home My Harbor" event is coming up on August 26th between 8:30-1:30pm. Julie Nygaard stated that the UBON Festival is the weekend of the 22nd. Julie Nygaard also noted that the TCMC Board of Directors passed a motion that TCMC will not be issuing grants in the 2018 FY in an effort to review the grant distribution process.		

Tri-City Healthcare District

Community Healthcare Alliance Committee (CHAC)

MEETING MINUTES

July 20, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Next Meeting	No August meeting. The next meeting is scheduled for September 21, 2017.		
Adjournment	The July 20, 2017 CHAC meeting was adjourned at 1:21pm.		

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
July 18, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Scott Livingstone,
Others:	Jeremy Raimo, Jane Dunmeyer, Marcia Cavanaugh, Steve Berner, Sharon Schultz, Charlene Carty, Jessica Ruh, Eva England, Mary Diamond, Kevin McQueen, Sherry Miller, Mark Albright, Greg Moser (Procopio), Barbara Hainsworth
Members Absent:	Dr. Gene Ma, Kapua Conley, Wayne Knight, Steve Harrington

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:32 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved to accept the agenda of July 18, 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 Nygaard
4. Ratification of minutes of June 20, 2017	Minutes were ratified with one correction noted.	Minutes were ratified with one correction noted. **MOTION** **It was moved by Director Mitchell, Director Kellett seconded, that the minutes of June 20, 2017 are to be approved with one correction. Director Kellett pointed out that on page 5, item 6.e. Physician Agreement for ED On-Call Coverage –**	

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
		Spine, Dr. Neville Alleyne's first and last names had been transposed. Barbara Hainsworth to make the correction	
5. Old Business			
6. New Business			
a. Policy Review • Cash Elective Procedures, #8610-263	Jessica Ruh detailed that this policy had undergone some minor language edits. Brief discussion ensued.	**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 approve policy Cash Elective Procedures, #8610-263.**	Jessica Ruh
b. Medical Staff Leadership Agreement – Physician Well-Being Committee Chair • Cary Mells, M.D.	Sherry Miller conveyed that Dr. Mells was to be appointed as the new Chair for the Physician Well-Being Committee. She further mentioned that while it is a new agreement appointing him to this role, the rate remains unchanged.	**MOTION** **It was moved by Director Kellett, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Cary Mells, M.D. as the Medical Staff Leadership Agreement for Chair of the Physician Well-Being Committee for a term of 24 months, beginning August 1, 2017 and ending July 31, 2019, not to exceed a total of $36,000 per year, total of $72,000 for the term.**	Sherry Miller
c. Medical Staff Leadership Agreement – Professional Behavior Committee Chair • Marcus Contardo, M.D.	Sherry Miller explained that this was a renewal agreement with Dr. Contardo to continue as the Chair of the Professional Behavior Committee at the same rates. Dr. Contardo was excused from the meeting room prior to this presentation, and did not participate in the discussion or the vote. Once	**MOTION** **It was moved by Mr. Lingenfelter, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Marcus Contardo, M.D. for Chair of the Medical Staff Professional Behavior Committee for**	Sherry Miller

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	the vote was accomplished, he returned to the proceedings.	**a term of 12 months beginning July 1, 2017 and ending June 30, 2018; minimum of 30 hours per month or 360 hours annually, for an annual cost of $60,000, and a total cost for the term of $60,000.**	
d. Physician Agreement for Chief of Staff – Medical Staff Leadership Agreement • Victor Souza, M.D.	Sherry Miller explained that this was a new agreement with Dr. Souza as the incoming Chief of Staff with new rates.	**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 approve the Medical Staff Leadership Agreement for Chief of Staff, Victor Souza, M.D. for a term of 23 months, beginning August 1, 2017 and ending on June 30, 2019, for a TCHD stipend of $5,950 per month, $71,400 annually and $136,850 for 23 months; plus an educational allowance up to $10,000 for a total not to exceed $146,850 for the term, paid by TCHD.**	Sherry Miller
e. Renewal EKG / Echocardiogram Panel Agreement for Coverage Physician • Mohammad Pashmforoush, M.D., Cardiology	Eva England conveyed that this agreement would add Dr. Pashmforoush to the existing EKG / Echocardiogram Panel Agreement for Coverage Physicians.	**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 Mohammad Pashmforoush, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018.**	Eva England
f. Physician Agreement for Cardiac Rehabilitation	Eva England conveyed that this agreement would add Dr. Showah	**MOTION** **It was moved by Director Kellett,**	Eva England

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
Supervision • Henry F. Showah, M.D.	to the Cardiac Rehabilitation Services Panel Agreement.	**Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Henry F. Showah, M.D. to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 and ending June 30, 2019.**	
g. Surgical Light Replacement & Video Integration Proposal, O.R. #3 • Stryker (Berchtold Lights & Stryker Video Integration) • Sun Structural Engineering (Design) • McCoy Construction (Construction / Installation)	Mary Diamond advised that this proposal is for the design, construction and installation of replacement surgical lights and a video system for OR #3. A brief discussion ensued, during which she conveyed that there are 7 additional operating rooms that will require surgical light replacement and video integration over the next couple of years.	**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 authorize the publicly bid agreement with McCoy Design & Construction for $95,025, and the purchase of equipment to replace the lights in operating room #3, for a total expected project cost of $445,379.63.**	Mary Diamond
h. Proposal to Develop an Institute for Clinical Effectiveness	Jeremy Raimo and Scott Livingstone presented the proposal to develop an Institute for Clinical Effectiveness. In addition, they also provided a comprehensive PowerPoint presentation. The Committee requested that this item be added to the Work Plan, with an updates to occur semi-annually. The initial update to take place in January 2018.	**MOTION** **It was moved by Mr. Lingenfelter, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the formation of an Institute for Clinical Effectiveness, LLC; TCMC membership in and purchase of membership units, and approve a co-**	Jeremy Raimo

Topic	Discussions, Conclusi Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
	A correction was noted on this write-up to edit Scott Livingstone's title from Interim Chief Operating Officer to Interim Chief Compliance Officer.	**management agreement with the LLC for a term of 34 months, beginning September 1, 2017 and ending June 30, 2020 for an annual cost of $750,000, and a total cost for the term of $2,125,000.** **Barbara Hainsworth to amend the write-up**	
i. Financials	Ray Rivas conveyed that there were no financials distributed for June due to the upcoming fiscal year-end audit. A pre-audit was undertaken in May and Moss-Adams will be on-site once again in August. The finalized audit report is projected for completion in September. He also conveyed that the FY2018 Budget had been approved by the Board of Directors.		
j. Work Plan – Information Only			
• Wellness Center	*(deferred until August)*		David Bennett
• Construction Report	No discussion		Steve Berner
• ED Throughput	Sharon Schultz gave a brief review of the dashboard document included in the packet.		Candice Parras
• Neuroscience Institute – NSI Medical Directorships	Jeremy Raimo gave a brief status update on the progress of the Neuroscience Institute and its Medical Directors.		Wayne Knight
• Medical Director – Surgery	*(deferred until August)*		Mary Diamond
• IT Physician Liaison	*(deferred until August)*		Mark Albright

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	son(s) Responsible
• Crisis Stabilization Unit (CSU) Update	Sharon Schultz reviewed the CSU dashboard documents included in the packet for April – June 2017.		Sharon Schultz
• Dashboard	No discussion		Ray Rivas
7. Comments by committee members	None		
8. Date of next meeting	August 22, 2017		Chair
9. Community Openings (3)			
10. Adjournment	Meeting adjourned 1:36 p.m.		

Tri-City Health Care District
Oceanside, California

Administrative Policy

~~6.a.~~

ISSUE DATE: 08/97 **SUBJECT:** CASH ELECTIVE ~~SURGICAL~~ PROCEDURES

REVISION DATE: 01/99; 05/03; 01/06; 09/10; 06/14 **POLICY NUMBER:** 8610-263

Department Approval:	04/17
Administrative Policies and Procedures Committee Approval:	~~12/13~~ 06/17
Finance & Operations Committee Approval:	~~06/14~~07/17
Board of Directors Approval:	06/14

A. **PURPOSE:**

1. To establish payment guidelines for patients with financial means to pay for their elective ~~surgical~~ services.

B. **DEFINITIONS:**

1. Cash Patient: A patient who is not currently eligible for a federal, state, other government program, ~~or~~ who is not currently an eligible subscriber/dependent under an insurance plan, **or who has insurance but is seeking to obtain services that are not a covered benefit under their insurance plan**.

C. **POLICY:**

1. The ~~Main Registration~~ Manager **of Patient Access** or designee has the responsibility for providing estimates for surgical services. The ~~Registration~~ **Patient Access** Department will notify the ~~Registration~~ Manager **of Patient Access** or designee on the Cash Payment Discount Policy form that an estimate and financial arrangements are needed.
2. At the time the Doctor's office calls to schedule ~~the~~ **a** procedure, ~~Surgery~~ Scheduling will be responsible for notifying the Doctor's office of the hospital's cash policy. Physician and/or patients' questions regarding prices and payment arrangements will be referred to the ~~Pre-Admit office~~ **Pre admitters of the Patient Access Department**.
3. **The ~~P~~patient is required to sign the Voluntary Waiver and Financial Agreement Form and p**ayment in full will be requested prior to the patient preoperative appointment. If the patient is unable to pay in full, a deposit of 50% of the estimate will be collected. The balance of the account must be settled and paid in full no later than six months after the final bill is received. Exceptions to usual deposit requirements and payment plans require approval from the ~~Director of Patient Financial Services~~ ~~**Director of Revenue Cycle**~~ **Manager of Patient Access** or designee.
4. Registration will inform the patient and/or physician of the payment requirements. If after ~~Patient Financial~~**Pre-Admission** Services ~~(PFS)~~ screening the patient cannot pay, the ~~Director of Registration~~ **Patient Access Manager** or designee, in consultation with the hospital's Chief Executive Officer designee will determine whether **the** elective ~~surgical services~~ **procedure** should be performed prior to the anticipated service date.
5. ~~Financial counseling through PFS is available to those patients that express an inability to pay. Personal assessment forms will be obtained to determine ability to pay or possible qualification for government assistance. A credit report may be done to evaluate the patient's financial status and patients will be asked to provide supporting documentation to determine financial need.~~
6. ~~5.~~ If a case is canceled, it will be the responsibility of the ~~Director of Registration~~ **Manager of Patient Access** or designee in consultation with the Chief Executive Officer or Vice President Designee to inform the physician and ~~Registration~~ **Patient Access**.
6. Procedures may be scheduled when:

~~7.~~**a.** **Patient has signed the Voluntary Waiver and Financial Agreement Form.**

~~a.~~**b.** Deposit requirement has been paid and payment of balance arranged.

~~b.~~**c.** Patient has become eligible for a federal, state or other government-funded program, or is now currently enrolled as covered person under an insurance plan.

~~c.~~**d.** With the approval of the Chief Executive Officer or Vice President designee.

7. ~~Registration~~ **Patient Access** will be responsible for notifying ~~surgery~~ scheduling that a ~~case~~ **procedure** is canceled so it can be removed from the schedule.

D. **FORM(S):**

~~8.~~**1.** **Voluntary Waiver and Financial Agreement Form**

VOLUNTARY WAIVER AND FINANCIAL AGREEMENT

(Please read carefully and do not sign unless you understand the document.)

I, _____ (patient name) am seeking medical treatment from Tri-City Healthcare District, a California healthcare district, on behalf of Tri-City Medical Center ("Tri-City Medical Center" or "Hospital").

Check One:

_____ I am a member of a health plan that has not authorized services at Tri-City Medical Center, so I will be responsible for paying for the services provided by the Hospital.

_____ I am a member of a health plan, but choose to pay for the services I receive at Hospital myself and I understand that any reimbursement from my health plan will be my responsibility.

_____ I am not a member of any health plan and I will be responsible for the payment of $_____ (ESTIMATED) owed to Tri-City Medical Center for services provided.

_____ I am a member of a health plan and understand that the services I am going to receive at Tri-City Medical Center are not "Covered Services" under my health plan and therefore, I will be responsible for paying for the services provided by the Hospital.

This Section MUST be Fully Completed:

- The specific services being provided are:

  _____

  If I am electing to have services that are not "Covered Services" (as checked above), I understand my health insurance does not provide coverage for these services under my benefit plan or my insurance has determined that these services are not medically necessary or are experimental or investigational.

- The ESTIMATED Cash Payment Amount I will owe for these services is: $_____

  I understand that this amount is an ESTIMATE based on the services my physician has indicated will be performed. Any change in the services my physician actually performs may change this estimate.

- Scheduled date of service: _____

Therefore, by signing this form, I agree:

1. I have read and understand the services and agreed upon payment rates as outlined above and all of my questions have been answered to my satisfaction; and
2. I understand this estimate is for hospital services ONLY and does not include any fees charged by physicians; and
3. I will be solely responsible for Tri-City Medical Center's charges as outlined above; and
4. If I am a member of a health plan, Tri-City Medical Center will not seek payment from my health plan; and
5. If I incur any additional fees, they will be due at the time of my discharge.

_____

Patient Signature Date / Time

_____

Signature of Financially Responsible Party (if not patient) Date / Time

_____

Print Name of Financially Responsible Party (if not patient)

_____

Signature of Hospital Representative Date / Time

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
Medical Staff Leadership Agreement – Physician Well-Being Committee Chair

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

Physician's Name: Cary Mells, M.D.

Area of Service: Medical Staff: Physician Well-Being Committee Chair

Term of Agreement: 24 months, Beginning, August 1, 2017 – Ending, July 31, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current Medical Staff Area of Service Coverage: Physician Well-Being

Rate/Month	Annual Term Cost	Total Term Cost
$3,000	$36,000	$72,000

Position Responsibilities:

- Perform the duties of Chair of the Physician Well-Being Committee as set forth in the Tri-City Healthcare District Medical Staff Bylaws.
- Be available as a resource to the Medical Staff and Hospital with respect to well beng issues.
- Liaise with Hospital Administration and Medical Staff on issues relating to physician well being programs.

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	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 authorize Cary Mells, M.D. as the Medical Staff Leadership Agreement for Chair of the Physician Well-Being Committee for a term of 24 months, beginning August 1, 2017 and ending July 31, 2019, not to exceed a total of $36,000 per year, total of $72,000 for the term.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
Medical Staff Leadership Agreement – Professional Behavior Committee Chair

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

Physician's Name: Marcus Contardo, M.D.

Area of Service: Medical Staff: Professional Behavior Committee Chair

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current Medical Staff Area of Service Coverage: Professional Behavior

Minimum Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
30	360	$5,000	$60,000	$60,000

Position Responsibilities:

- Perform the duties of Chair of the Professional Behavior Committee, as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Implement the Medical Staff Professional Behavior Policy #8710-57 (previously numbered 8710-511.1)

Document Submitted to Legal:		Yes	X	*No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	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 authorize the agreement with Marcus Contardo, M.D. for Chair of the Medical Staff Professional Behavior Committee for a term of 12 months beginning July 1, 2017 and ending June 30, 2018; minimum of 30 hours per month or 360 hours annually, for an annual cost of $60,000, and a total cost for the term of $60,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
PHYSICIAN AGREEMENT FOR CHIEF OF STAFF
MEDICAL STAFF LEADERSHIP AGREEMENT, Victor Souza, M.D.

Type of Agreement		Medical Director		Panel		Other:
Status of Agreement	X	New Agreement	X	New Rates		Same Rates

Physicians Name: Victor Souza, M.D.

Area of Service: Chief of Staff, Medical Staff Leadership

Term of Agreement: 23 months, Beginning, August 1, 2017 – Ending, June 30, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Est. Rate/Hour	Hours per Month	Hours per Year	Monthly Stipend (TCHD)	Annual Stipend (TCHD)	Education Expense (TCHD) for Term	Cost for 23 Month Term (TCHD)
$148.75	40	480	$5,950	$71,400	$10,000	$146,850

Position Responsibilities:

- Previous monthly stipend amount: $4,000
- Perform the duties of Chief of Staff as set for the in the Tri-City Healthcare District Medical Staff Bylaws
- Attend meetings of the Board of Directors and such Board Committees as may be requested from time-to-time, including the Professional Affairs Committee.
- Liaise with Hospital Administration, including reporting on the status of activities of the Medical Staff.
- Attend Education training, including Greeley training regarding Credentialing and Peer Review

Document Submitted to Legal:		Yes	X	No
Approved by Chief Compliance Officer:	X	Yes		No
Is Agreement a Regulatory Requirement:		Yes	X	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 the Finance, Operations and Planning Committee recommend the TCHD Board of Directors approve the Medical Staff Leadership Agreement for Chief of Staff, Victor Souza, M.D. for a term of 23 months, beginning August 1, 2017 and ending on June 30, 2019, for a TCHD stipend of $5,950 per month, $71,400 annually and $136,850 for 23 months; plus an educational allowance up to $10,000 for a total not to exceed $146,850 for the term, paid by TCHD.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
RENEWAL EKG/ECHOCARDIOGRAM PANEL AGREEMENT for COVERAGE PHYSICIAN

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

Physician's Name: Mohammad Pashmforoush, M.D.

Area of Service: Cardiology

Term of Agreement: 12 months, Beginning, July 1, 2017 – Ending, June 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Weekly Cost Not to Exceed	Annual Cost Not to Exceed	Total Term Cost Not to Exceed
$3,000	$156,000	$156,000

Position Responsibilities:

- Panel Physician shall interpret echocardiographic studies of unassigned patients for which the attending physician does not specify an interpreting cardiologist.
- Electrocardiograms are to be interpreted twice daily on weekdays, Monday-Friday, and at least once per day on weekends, Saturday, Sunday or holidays.
- The final report for all echocardiograms is to be dictated within 24 hours of the performance of the study.
- For exercise of pharmacological stress test, if the scheduled Panel Physician cannot be available within 15 minutes of the scheduled start time to personally supervise the test, it is that Panel Physician's responsibility to assure that another cardiologist will do so. The final report shall be dictated on the day of the study.
- Panel Physician agrees to compare ECG's with previous, if available.

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: Eva England, Cardiovascular Service Line Administrator / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Mohammad Pashmforoush, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology for a term of 12 months, beginning July 1, 2017 and ending June 30, 2018.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
PHYSICIAN AGREEMENT for Cardiac Rehabilitation Supervision

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

Physician's Name: Henry F. Showah, M.D.

Area of Service: Cardiac Rehabilitation Services, On-Site and Wellness Center

Term of Agreement: 23 months, Beginning, August 1, 2017 – Ending, June 30, 2019

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES

Rate / Hour	Hours per Month	Monthly Cost	23 month (Term) Cost
$148.30	39	$5,784	$133,032

Position Responsibilities:

- Cardiac Rehabilitation Wellness Center Supervising Physician in accordance with CMS 42 CFR 410.49 (Direct supervision of the Cardiac Rehabilitation program by a physician is a requirement).
- Maintain cardiac rehabilitation program as a physician directed clinic.
- Providing medical supervision of patients receiving services in the Department, and clinical consultation for the Department as requested by attending physicians including, without limitation, daily review and monitoring of patients receiving services in or through the Department.
- Ensuring that all medical and therapy services provided by the Department, Program or Service are consistent with Hospital's mission and vision.
- Supervising the preparation and maintenance of medical records for each patient receiving services in or through the Department.
- Evaluation of all Phase 2 patients enrolled in the Cardiac Rehabilitation Program and ongoing supervision and evaluation of monitored exercise sessions.
- Attend meetings with Hospital administration, Hospital's medical staff as required by Hospital and/or Dept.
- Participate in and otherwise cooperate with continuing education and in-service training of Department Personnel and others working in Department.
- Assure that adequate medical coverage is provided for Cardiac Rehabilitation clinical services activities performed within Department during hours of operation.

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: Eva England, CV Service Line Administrator/ Kapua Conly Chief Operating Officer

[illegible]tion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Henry Showah, M.D. to the existing panel of supervising physicians of the Cardiac Rehabilitation program for vacation and sick day coverage for Drs. Slowik and El-Sherief for a term of 23 months, beginning August 1, 2017 and ending June 30, 2019.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
SURGICAL LIGHT REPLACMENT AND VIDEO INTEGRATION PROPOSAL, O.R. #3

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

Vendor's Name: Stryker (Berchtold Lights and Stryker Video Integration)
Sun Structural Engineering (Design)
McCoy Construction (Construction/Installation)

Area of Service: Surgery

Term of Agreement: One-Time Purchase

Maximum Totals:

Item:	**Amount:**
• Purchase of Berchtold F-Generation Surgical Lights and ChromoVision Camera System Full HD for E	$77, 593.78
• Purchase of SwitchPoint Infinity All-in-One HD Digital Routing System, ProCare Service Plan for Three (3) Years and Misc. Accessories	$113,983.96
• Purchase of SDC 3 Base w/SDP 1000 printer kit and wireless transmitter	$44,011.31
• Construction (publicly bid agreement with McCoy Design & Construction)	$95,025.00
• Design Services, Inspection Services, Permit Fees, Contingency	$71,322.50
• Cabinet Substerile OR 3/OR 4	$10,452.00
• 8% Tax, Shipping & Handling	$32,991.08
Total Expected Cost:	**$445,379.63**

Description of Services/Supplies:

- Replacement of Surgical Lights in OR 3 , along with installation of an integration system to allow for better image availability during minimally invasive surgery and storage of images:

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

Person responsible for oversight of agreement: Mary Diamond, Sr. Director, Nursing, Surgical Services / Sharon Schultz, Chief Nurse Executive

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the publicly bid agreement with McCoy Design & Construction for $95,025, and the purchase of equipment to replace the lights in operating room #3, for a total expected project cost of $ 445,379.63.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: July 18, 2017
PROPOSAL TO DEVELOP AN INSTITUTE FOR CLINICAL EFFECTIVENESS

Type of Agreement		Medical Directors		Panel	X	Other: LLC Formation & Co-Management Agreement
Status of Agreement	X	New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Institute for Clinical Effectiveness, LLC

Area of Service: Emergency Department; Anesthesia; Hospitalist Services; Surgery

Term of Agreement: 34 months, Beginning, September 1, 2017 – Ending, June 30, 2020

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$62,500	$750,000	$2,125,000

Description of Services/Supplies:

- Establish Institute as the infrastructure to drive patient outcomes and quality improvement across the care continuum for patients in TCMC primary and secondary service areas
- Pursue timely business development opportunities including potential business ventures
- Position Tri-City and physicians for new delivery models under healthcare reform through the use of real-time data analytics and modeling techniques

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

** Legal review by Squire, Patton, Boggs, LLP; clinical institute structure previously reviewed by Procopio*

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Scott Livingstone, Interim Chief Compliance Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the formation of an Institute for Clinical Excellence, LLC; TCMC membership in and purchase of membership units, and approve a co-management agreement with the LLC for a term of 34 months, beginning September 1, 2017 and ending June 30, 2020 for an annual cost of $750,000, and a total cost for the term of $2,125,000.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
July 13, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, Director Leigh Anne Grass, Dr. Contardo, Dr. Souza and Dr. Johnson.

Non-Voting Members Present: Scott Livingstone Interim Chief Compliance Officer, Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director Quality and Regulatory.

Others Present: Lisa Mattia, Tori Hong, Kathy Topp, Diane Sikora, Sharon Davies, Nancy Myers, Amy Hardt, Eva England, Mary Diamond, Kelli Kelli Larose, Robert Flores, Kevin McQueen, Sherry Miller, Steve Young, Jeremy Raimo, Patricia Guerra and Karren Hertz.

Members Absent: Dr. Gene Ma, Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:08 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	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
4. Ratification of minutes of June 2017.	Director Mitchell called for a motion to approve the minutes from June 8, 2017 meeting.	The minutes were ratified and was approved by the group. Director Dagostino moved and	Karren Hertz

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		Dr. Contardo seconded the motion to approve the minutes from June 2017.	
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. ALARIS System Data Set Transfer Procedure 2. Black Box Warnings; Drugs With Policy 3. Management of ECG Strips 4. Medication Administration Policy 5. Patient and Family Education Policy 6. Patient Rights and Responsibilities	There was no discussion on this policy. There was no discussion on this policy. It was clarified that while the monitor techs identify the changes in the patients' ECGs; the RNs are trained in interpreting them. Some of the items that are not allowed in the bedside are eye drops, inhaler and nasal spray. Wound care supplies, on the other hand, can be left at the patient's bedside. It was noted that pain management is done mostly by nurses in the unit. The hospital covers patient rights per regulatory guidelines-- in the handbook, and they are also posted in each unit. The payment for services provided is covered when the patient signs their COA (Condition	**ACTION:** The Patient Care Services policies and procedures were approved. Director Dagostino moved and Dr. Contardo 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
	on Admission). The COA allows the facility to treat with the patients' permission.		
7. Program Flexibility	Jami explained to the group the specifics of program flexibility. CDPH has a process in place when the hospital needs to provide care outside of their standards. CDPH grant these exceptions on a limited basis for a limited time.		
8. Referrals to Social Services for Psychosocial Assessment Policy	Director Leigh Anne Grass was asking if it is possible to add the spiritual assessment to this policy. Scott Livingstone mentioned that the patient's spiritual need is included in the admission assessment of patients coordinated by the social workers.		
9. Therapeutic Anticoagulation Management Policy	There was no discussion on this policy.		
10. Vaccination Administration	There was no discussion on this policy.		
11. Vaccine, Reporting Adverse Events Policy	There was no discussion on this policy.		
12. Vasc Band Hemostat: Radial Artery Compression Device	There was no discussion on this policy.		
13. Wasting Narcotics , Documentation in the Pyxis Machine	The group had a brief discussion on wasting narcotics which usually happen when either a patient only needs 1 mg out of a 2mg vial or if there is a spill. This should be properly documented so the patients don't get		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	charged inaccurately.		
Administrative Policies and Procedures:			
1. Assault and Battery Reporting Process	The assault and abusive conduct definition was modified to say "included but not limited to" in the section outlining the offenses.	**ACTION:** The Administrative policies and procedures were approved. Director Grass moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Assault Victims/ Domestic Violence Reporting Requirements	This policy provides guidelines with the mandatory reporting requirements for any patient injuries incurred through assault presented at TCHD. The reporting responsibility is out of the victim's hands as healthcare workers are mandated to report such incidents.		
3. Business Associate Agreement- Physician Offices Granted Access to Electronic Healthcare Record (CERNER)	This policy is being pulled out for further clarification.		
4. Business Associate Agreement, Clinical Information System (CERNER) Access, Physician and Physician Office Employees: Onsite and Remote	This policy is being pulled out for further clarification.		
5. Consent for Photograph/ Videotape	This policy was discussed thoroughly in the Audit and Compliance Committee and is moving forward for BOD approval.		
6. Designation of Authority in	It was noted that this policy is not		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Absence of CEO	considered a succession policy. Details of this policy will be debated at a higher level in the Governance Committee in August. This policy is being pulled as suggested by Director Leigh Anne Grass.		
7. Handling of Pharmaceutical Waste, Expired Medications	It was reported that there are new processes in place in handling pharmaceutical waste when it comes to narcotics.		
8. Remote Access: Physicians and Physician Office Employees	There was no discussion on this policy.		
9. Reporting Suspected Child Abuse/ Neglect	The report of suspected abuse creates an alert on the internal check system of the hospital's social workers.		
10. Reporting Suspected Dependent Adult/ Elder Abuse/ Neglect	It was recommended that the definition of mandated reporter should be clearly established and exactly the same for both child abuse and elder abuse.		
Unit Specific **Infection Control**			
1. Epidemiologic Investigation of a Suspected Outbreak	In cases of an outbreak, it was clarified that the CEO will always let the BOD know as soon as possible.	**ACTION:** The Infection Control policies were all approved. Director Grass moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Hand Hygiene	A clarification was made that the staff can use hand sanitizers in lieu of soap and water for handwashing. However, if the hands are visibly soiled, soap and water is still necessary.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
3. Management of Patients with AIDS	The title of this policy was modified. The committee made a recommendation to add HIV Infection to the title.		
Medical Staff			
1. Credentialing Criteria, Cardiac Rehab (Outpatient)	Sherry Miller stated that most of the policies contained in this section are credentialing of medical sub-specialties.	**ACTION:** The Medical Staff policies and procedures were proved. Director Dagostino moved and Dr Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Credentialing of Emergency Medicine Physicians for Emergency Ultrasounds	There was no discussion on this policy.		
3. Criteria for Granting Moderate and Deep Sedation/ Analgesia Privileges to Non-Anesthesiologists	The group had a discussion on deep sedation; there was a recommendation to have this policy move forward although the definition of sedation according to CMS will be added/ modified by Jami.		
4. Neonatal Narcotic Withdrawal/Abstinence Syndrome, Pharmacological Treatment- Tracked Changes Neonatal Narcotic Withdrawal/Abstinence Syndrome Pharmacological Treatment – Clean Copy	It was agreed that upon approval of this policy, it will be transferred to the Women's and Children's department manual.		
5. Peer Review Process: OPPE and FPPE	Dr. Johnson briefly mentioned that the OPPE process is getting to be more in-depth.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
6. Supervision of Residents in Emergency Medicine	Sherry Miller identified that there are 4 to 5 residents per year in the Emergency Department.		
NICU			
1. Formula, Preparation and Storage of	There was no discussion on this policy.	**ACTION:** The NICU procedure was approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health			
1. Appointment of Representative Form	The policy is being enforced as a matter of competency as reported by Kelli Larose.	**ACTION:** The Outpatient Behavioral Health policies were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Daily Schedule	The daily schedule for outpatient behavioral health patients need to be documented for CMS reference.		
3. Denied Payment	There was question raised by Director Dagostino if this policy is needed. There was a decision to pull this policy for further investigation since the hospital needs to have a standard procedure when it comes to billing and reimbursement for all units.		
4. Department Safety	There was no discussion on this policy.		
5. Disclosure of Information Over the Telephone	This policy is being pulled out for further investigation. There was a discussion that this policy should be in compliance with the hospital's standard policies. It should be treated the same for inpatient , outpatient and behavioral health.		
6. Downtime Procedures			

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. Emergency Evacuation	There was no discussion on this policy.		
8. Exchange and Replacement of Medication	There was no discussion on this policy.		
9. Financial Assessment	There was no discussion on this policy.		
10. Fire Safety	There was no discussion on this policy.		
11. Food Service Procedures	The references for this policy need to be checked and updated.		
12. Inclement Weather and Critical Incident Policy	There was no discussion on this policy		
13. Medicare Additional Development Request	There was some minor typo for this policy; the title should say "document" not development. This policy should also be in compliance with the standard policies of the hospital. It is being pulled out for further modifications.		
14. Orientation of New Patients	The orientation list of patient officially go in the chart of the patient for outpatient behavioral health patients.		
15. Pastoral Care	There was no discussion on this policy.		
16. Patient Complaints	This policy is being pulled for further review. Marcia Cavanaugh will have some input for this policy as it gets revised and brought back to the committee.		
17. Practicum Student Placement	There was no discussion on this policy		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
18. Release of Information	It was mentioned that the Outpatient Behavioral Health should use the hospital version of Release of Information for consistency purposes. This policy is being pulled out for some revisions and modifications.		
19. Staff Meetings	There was no discussion on this policy.		
20. Staffing Levels	Kelli specified that the Outpatient Behavioral Health does not have a director so this policy (and the other policies in this section) should reflect that the head of the department is an Operations Manager and not a director.		
21. Transportation of Patients	This policy needs to be pulled for further review and research as there are new requirements for the driver that just recently came up according to Jami Piearson.		
Outpatient Infusion Center			
1. Age-Specific Guidelines	There was no discussion on this policy.	**ACTION:** The policies and procedures for Outpatient Infusion Center were approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Data Management	The data for this department is tied up with the hospital's CERNER system.		
3. Diagnostic Tests	There was no discussion on this policy.		
4. Disseminating Medical Information	There was no discussion on this policy.		
5. Environment of Care	There was no discussion on this policy.		
6. History and Physical	Diane mentioned that patients for the Infusion Center have limited H & P.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
7. Medical Emergencies	This policy is being pulled out for further revisions and modifications.		
8. Medical Equipment Maintenance	There was no discussion on this policy.		
9. Medical Record Review	The term LVN should be removed as the hospital does have any LVN's anymore.		
10. Patient Instructions	There was no discussion on this policy.		
11. Patient Record Content	There was no discussion on this policy.		
12. Registration of Patients	There was no discussion on this policy.		
13. Scheduling and Receiving Patients	There was no discussion on this policy.		
14. Scope of Services	It was noted that there is no blood transfusion being done in the infusion center.		
15. Staffing Plan	There was no discussion on this policy.		
16. Standards of Care	There was no discussion on this policy.		
17. Department Specific Orientation	There was no discussion on this policy.		
Pharmacy			
1. Automatic IV to Oral Conversion	There was no discussion on this policy.	**ACTION:** The Pharmacy policies were all approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving	Patricia Guerra
2. Pharmaceutical Representatives	Tori stated that the Pharmacy Department tries to control the traffic of vendors in their		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	area. There was a recommendation to add the APP policy on Business Visitors as a reference to this policy.	forward for Board approval.	
Pulmonary			
1. Authorization to Perform (Respiratory Care Students)	This policy refers to the respiratory care students in the patient care areas and their respective authorization to perform certain procedures in accordance to their residency program.	**ACTION:** The Pulmonary policies were all approved. Dr. Souza moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Procedural Triage	The references in this policy need to be updated.		
Surgical Services			
1. Cell Saver Set-Up, Use and Monitoring	Mary Diamond confirmed to the group that the OR is still using this equipment (Cell-Saver).	**ACTION:** The Surgical Services policies were all approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Visitors in the OR Policy	Mary emphasized that they are currently limiting the number of visitors in the OR (a few of the visitors are PT students). This policy was also recommended to use the APP policy for Business Visitors Policy as a reference.		
Women and Newborn			
1. Infant Transport Intra-facility	There was no discussion on this policy.	**ACTION:** The WNS were all approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Standards of Care : Intrapartum	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Pre-Printed Orders 1. Central Venous Access Device Flushes 2. Outpatient Extracorporeal Shock Wave Lithotripsy	There was no discussion on this policy. There was no discussion on this policy.	**ACTION:** The pre-printed orders were all approved. Director Dagostino moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	
6. Clinical Contracts	Scott Livingstone, who was appointed as the Interim Chief Compliance Officer, reported on the clinical contracts for the month of June.	**ACTION:** The clinical contracts were approved to move forward to go to the Board for this month.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:20 PM.	Director Mitchell
8. Return to Open Session	The Committee return to Open Session at 3:43.		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 3:45 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
July 13, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Alaris System Data Set Transfer Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
2. Black Box Warnings, Drugs with Policy	3 Year Review	Forward to BOD for Approval
3. Management of ECG Strips	NEW	Forward to BOD for Approval
4. Medication Administration Policy	3 Year Review, Practice Change	Forward to BOD for Approval
5. Patient and Family Education Policy	3 Year Review	Forward to BOD for Approval with Revisions
6. Patient Rights and Responsibilities 302	3 Year Review	Forward to BOD for Approval
7. Program Flexibility	NEW	Forward to BOD for Approval
8. Referrals to Social Services for Psychosocial Assessment policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
9. Therapeutic Anticoagulation Management Policy	3 Year Review, Practice Change	Forward to BOD for Approval
10. Vaccination Administration	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
11. Vaccine, Reporting Adverse Events Policy	3 Year Review	Forward to BOD for Approval
12. Vasc Band Hemostat: Radial Artery Compression Device	NEW	Forward to BOD for Approval
13. Wasting Narcotics via the Pyxis	3 Year Review, Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Assault and Battery Reporting Process 241	3 Year Review, Practice Change	Forward to BOD for Approval
2. Assault Victims Domestic Violence Reporting Req 310	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
3. Business Associate Agreement-MD Offices Granted Compass Access 625	DELETE	Pulled for Further Review
4. Clinical Information System (COMPASS) - MDs and MD Offices 622	3 Year Review, Practice Change	Pulled for Further Review
5. Consent for Photograph_Videotape 372	3 Year Review, Practice Change	Forward to BOD for Approval
6. Designation of Authority in Absence of CEO 233	3 Year Review, Practice Change	Pulled for Further Review
7. Handling of Pharmaceutical Waste, Expired Medications 276	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
8. Remote Access Physicians and Phys Offices 620	DELETE	Forward to BOD for Approval
9. Reporting Suspected Child Abuse_Neglect 308	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
10. Reporting Suspected Dependent Adult Elder Abuse Neglect 309	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
Unit Specific		
Infection Control		
1. Epidemiologic Investigation of a Suspected Outbreak - IC 3	3 Year Review, Practice Change	Forward to BOD for Approval

PROFESSIONAL AFFAIRS COMMITTEE
July 13, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
2.	Hand Hygiene - IC 8	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
3.	Management of Patients with AIDS - IC 6.1	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Medical Staff		
1.	Credentialing Criteria, Cardiac Rehab 8710-564	3 Year Review	Forward to BOD for Approval
2.	Credentialing of Emergency Medicine Physicians for Emergency Ultrasounds 8710-522	3 Year Review	Forward to BOD for Approval
3.	Criteria For Granting Moderate and Deep Sedation Analgesia Privileges to Non-Anes 8710-517	3 Year Review	Forward to BOD for Approval with Revisions
4.	Neonatal Narcotic Withdrawal Syndrome, Pharmacological Treatment of 8710-559 – **Tracked Changes** Neonatal Narcotic Withdrawal Syndrome, Pharmacological Treatment of 8710-559 – **Clean Copy**	3 Year Review, Practice Change	Forward to BOD for Approval
5.	Peer Review Process: OPPE and FPPE 8710-509	Practice Change	Forward to BOD for Approval
6.	Supervision of Residents in Emergency Medicine 8710-571	Practice Change	Forward to BOD for Approval
	NICU		
1.	Formula, Preparation and Storage of	3 Year Review, Practice Change	Forward to BOD for Approval
	Outpatient Behavioral Health		
1.	Appointment of Representative	3 Year Review	Forward to BOD for Approval
2.	Daily Schedule	3 Year Review	Forward to BOD for Approval
3.	Denied Payment	3 Year Review	Pulled for Further Review
4.	Department Safety	3 Year Review	Forward to BOD for Approval
5.	Disclosure of Information over the telephone	3 Year Review	Pulled for Further Review
6.	Downtime Procedures	3 Year Review	Forward to BOD for Approval
7.	Emergency Evacuation	3 Year Review	Forward to BOD for Approval
8.	Exchange and Replacement of Medication	3 Year Review	Forward to BOD for Approval
9.	Financial Assessment	3 Year Review	Forward to BOD for Approval
10.	Fire Safety	3 Year Review	Forward to BOD for Approval with Revisions
11.	Food Service Procedures	3 Year Review	Forward to BOD for Approval with Revisions
12.	Inclement Weather and Critical Incident Policy	3 Year Review	Forward to BOD for Approval
13.	Medicare Additional Development Request	3 Year Review, Practice Change	Pulled for Further Review

PROFESSIONAL AFFAIRS COMMITTEE
July 13, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
14. Orientation of New Patients	3 Year Review, Practice Change	Forward to BOD for Approval
15. Pastoral Care	3 Year Review, Practice Change	Forward to BOD for Approval
16. Patient Complaints	3 Year Review, Practice Change	Pulled for Further Review
17. Practicum Student Placement	3 Year Review, Practice Change	Forward to BOD for Approval
18. Release of Information	3 Year Review, Practice Change	Pulled for Further Review
19. Staff Meetings	3 Year Review, Practice Change	Forward to BOD for Approval
20. Staffing Levels	3 Year Review, Practice Change	Forward to BOD for Approval
21. Transportation of Patients	3 Year Review, Practice Change	Pulled for Further Review
Outpatient Infusion Center		
1. Age-Specific Guidelines	3 Year Review	Forward to BOD for Approval
2. Data Management	3 Year Review, Practice Change	Forward to BOD for Approval
3. Diagnostic Tests	3 Year Review	Forward to BOD for Approval
4. Disseminating Medical Information	3 Year Review	Forward to BOD for Approval
5. Environment of Care	3 Year Review, Practice Change	Forward to BOD for Approval
6. History and Physical	3 Year Review, Practice Change	Forward to BOD for Approval
7. Medical Emergencies	3 Year Review	Pulled for Further Review
8. Medical Equipment Maintenance	3 Year Review	Forward to BOD for Approval
9. Medical Record Review	3 Year Review	Forward to BOD for Approval with Revisions
10. Patient Instructions	3 Year Review	Forward to BOD for Approval
11. Patient Record Content	3 Year Review	Forward to BOD for Approval
12. Registration of Patients	3 Year Review	Forward to BOD for Approval
13. Scheduling and Receiving Patients	3 Year Review	Forward to BOD for Approval
14. Scope of Services	3 Year Review	Forward to BOD for Approval
15. Staffing Plan	3 Year Review	Forward to BOD for Approval with Revisions
16. Standards of Care	3 Year Review	Forward to BOD for Approval
17. Unit Specific Orientation	3 Year Review	Forward to BOD for Approval
Pharmacy		
1. Automatic I.V. to Oral Conversion	3 Year Review, Practice Change	Forward to BOD for Approval
2. Pharmaceutical Vendors	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions

PROFESSIONAL AFFAIRS COMMITTEE
July 13, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
	Pulmonary		
1.	Auth to Perform (Respiratory Students)	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2.	Procedural Triage	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Surgical Services		
1.	Cell Saver Set-Up, Use and Monitoring Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Visitors in the OR Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
	Women and Newborn		
1.	Infant Transport- Intrafacility	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Standards of Care: Intrapartum	3 Year Review, Practice Change	Forward to BOD for Approval
	Pre-Printed Orders		
1.	Central Venous Access Device Flushes 8711-4521	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Outpatient Extracorporeal Shock Wave Lithotripsy Orders 8711-1513	DELETE	Forward to BOD for Approval

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ALARIS SYSTEM DATA SET TRANSFER**
Purpose:	To outline the process for transferring the Guardrails data set on the Alaris Server and distributing it to the Alaris PCs on the Alaris network.

A. **PROCEDURE:**

1. The Pharmacy Clinical ~~Coordinator~~**Manager**/designee shall import the data set file into the Alaris Systems Manager application using the import option.
2. The Pharmacy Clinical ~~Coordinator~~**Manager**/designee shall confirm the correct data set has been imported by visually comparing the data set name and data set identification (ID) number from the Guardrails Editor report and comparing them to the listing on the Alaris Systems Manager page.
   a. Once imported, the data set is ready to be transferred to the Alaris PCs.
3. The Pharmacy Clinical ~~Coordinator~~**Manager**/designee shall notify Managers/Educators/Assistant Nurse Managers (ANMs)/~~Clinical Engineering~~**Bio-Medical Engineering** of new data sets and ID number.
4. Upon notification of new data set and ID number, the Manager/Educator/ANM shall:
   a. Educate clinical staff of new data set ID number
   b. Inform staff the new data set will become available after the Alaris PC has been powered off, then on, and "New Patient" is selected.
5. The Pharmacy Clinical ~~Coordinator~~**Manager**/designee shall set the imported data set file status to "active" in the Alaris Systems Manager application by clicking the "Transfer" button next to the data set name.
6. After waiting approximately 24 hours for the Alaris Systems Manager to complete the transfer of the data set to the Alaris PCs~~, Clinical Engineering shall request~~**, the Pharmacy Clinical Coordinator/designee shall** ~~the "Unsuccessful Upload" report.~~**review the Data Set Transfer Status Report Results**
   a. This report ~~is~~ **contains** a listing of the most recent communication sessions that resulted in the unsuccessful transfer of a data set file to the Alaris PC.
7. If the "Unsuccessful Upload" report contains a substantial number of entries, the Pharmacy Clinical ~~Coordinator~~**Manager**/designee shall wait 12 to 24 hours before ~~requesting~~ **running** another report.
8. If the "Unsuccessful Upload" report contains entries after it has been requested a second time, the report shall be printed and passed ~~to Sterile Processing Department (SPD) and~~ to **the** biomedical engineering department **and ~~Nursing~~ Educators/Assistant Nurse Managers**.
9. ~~SPD locate the Alaris PCs with serial numbers matching the report and ensure each is powered on and the "New Patient" screen is selected. The equipment shall then be given to the biomedical engineer for resolution.~~
10. ~~When all Alaris PCs in the report have been located and powered on, the biomedical engineer shall return to each of the Alaris PCs after a few minutes and check the data set version as follows:~~ ~~Nursing~~ **Educators/ANMs shall be notified to inspect each Alaris device in their patient care area to ensure that new Data Set is active by powering each unit on and selecting the "New Patient" screen. If not, they will contact biomedical engineering to inspect the device. For any device flagged for inspection, the biomedical engineer shall:**
    a. Power off the Alaris PC.
    b. Power on the Alaris PC.
    c. Leave the power on until the flashing computer icon on the lower left side of the Alaris PC screen stops flashing (approximately 1-2 minutes) and stays illuminated.
    d. Power the Alaris PC off and power on again, pressing "New Patient" to initiate the new data set.
    e. Validate the data set by:

Revision Dates	Clinical Policies & Procedures	Nursing Executive Council	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/05, 02/09, **04/17**	07/11, **05/17**	08/11, **05/17**	**05/17**	n/a	09/11, **07/17**	09/11

i. Checking the data set name at the upper left portion of the screen
ii. Selecting the desired profile and drug name in the drug library
iii. Scrolling down to the appropriate drug name

f. If an Alaris PC still contains the wrong version of the data set, move it closer to the network access point to ensure a stronger signal.

g. Leave the Alaris PC in place for several minutes before re-checking the data set version.

~~11.~~**10.** All out-of-service Alaris PCs except those that are non-functioning and awaiting repair shall be relocated within range of a network access point.

a. Power on all relocated Alaris PCs for 30 minutes, and then check the data set version.

~~12.~~**11.** After steps 9 and 10 above have been performed, the biomedical engineer shall ~~re-run the "Unsuccessful Upload" report and repeat steps 9 and 10 to update any PCs remaining on the report.~~**contact the Pharmacy Clinical Manager/designee to re-run the Data Set Transfer Status Report Results.**

~~13.~~**12.** If Alaris PCs still appear on the report after several communication sessions, the biomedical engineer shall **sequester and** report these Alaris PCs according to manufacturer instructions.

~~14.~~**13.** All equipment successfully repaired shall be returned to SPD for storage and/or distribution.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/08	**SUBJECT: Black Box Warnings, Drugs With**
REVISION DATE: 12/09, 5/13	**POLICY NUMBER: IV.I.1**

Department Approval:	**03/17**
Clinical Policies & Procedures Committee Approval:	**~~06/13~~05/17**
Nursing Executive Committee:	**~~07/13~~05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~07/13~~05/17**
Medical Executive Committee Approval:	**~~07/13~~06/17**
Professional Affairs Committee	**~~08/13~~07/17**
Board of Directors Approval:	**08/13**

A. **PURPOSE:**

1. Tri-City ~~Medical Center~~**Healthcare District (TCHD),** as part of their selection process for admission of a medication to the formulary, will determine if the medication contains a Food and Drug Administration (FDA) "Black Box~~ed~~ Warning" and determine the appropriate action and/or limitation required for the use of the drug within the organization.

B. **DEFINITIONS:**

1. Black Box~~ed~~ Warnings are specific product summaries of potential safety precautions and warnings of serious adverse reactions including potentially life-threatening effects. These warnings and information are required by the FDA. Black Box~~ed~~ Warnings can be found in the package insert. The FDA can require a pharmaceutical company to label a prescription medication with a Black Box~~ed~~ Warning, the strongest warning the FDA can require.

C. **POLICY:**

1. The Pharmacy Department will develop guidelines and protocols that are approved by the Pharmacy & Therapeutics (P&T) Committee to ensure medications are controlled and distributed properly.
2. ~~Tri-City Medical Center~~**TCHD** will develop a system for medications with Black Box~~ed~~ Warnings including but not limited to the following:
   a. Checklist or written guidelines for use
   b. Pre-printed orders/**e**~~E~~lectronic **o**~~O~~rders
   c. Dose limitations
   d. Packaging adjustments (warning labels, special packaging)
   e. A system of double checks in prescribing, dispensing and administration processes
3. All adverse events associated with Box~~ed~~ warning medications will be reported separately to the P&T Committee. The P&T Committee will review, trend and take appropriate action to minimize any future adverse events with Black Box~~ed~~ Warning medications.

D. **PROCEDURE:**

1. Identification
   a. Medications approved for use in the hospital will be annually reviewed for Black Box~~ed~~ Warnings.
   b. **TCHD**~~Tri-City Medical Center~~ shall maintain a list of the medications with Black Box Warnings that are most pertinent to the hospital patient population.
   c. Computer systems will alert the physician/pharmacist at the time of order entry if a drug contains a Black Box~~ed~~ Warning with special precautions.

d. **Labeling of** ~~D~~dispensed products~~, labeling~~ will notify the end user of Box~~ed~~ warnings with special precautions.

2. Guidelines, Protocols and Limitations
   a. From a list of formulary drugs with Black Box~~ed~~ Warnings, the P&T Committee will establish a subset of high priority drugs for focused attention. Analysis will be based on the severity risk level of the Black Box~~ed~~ Warning, adverse reactions history and frequency of utilization.
   b. The P&T Committee will assess the need to develop actions, guidelines or protocols for appropriate use of these medications. These guidelines and/or protocols will address appropriate actions to be considered by physicians, nurses and pharmacists in each medication management sub process. Actions may include:
      i. Prescribing
         1) Maximum/Minimum dosing range
         2) Evidence based justification for use of the medication
         3) Preprinted or special physician order forms **or electronic orders**
            a) Dose limitations
            b) Dosing orders written with dosing criteria/calculations (example: mg/m^2) in addition to final dose
         4) Written and/or approved by designated medical staff members competent in the use of the medication
         5) Appropriate monitoring orders
            a) Laboratory test
            b) Vital signs
      ii. Dispensing
         1) Warning label identifying "Black Box~~ed~~ warning alert" in dispensing area~~.~~
         ~~2) Independent double check of dose~~
         ~~3)~~**2)** Drug/drug interaction review
         ~~4)~~**3)** Pharmacist documented intervention with prescribing physician to confirm order and/or clinical discussion
         ~~5) Independent double check of medication preparation~~
         ~~6)~~**4)** Auxiliary labeling
         ~~7)~~**5)** Special packaging
         ~~8)~~**6)** Special transport procedures
      iii. Administration
         1) Warnings appropriate during administration of the drug
         ~~2) Independent double check of dosing and preparation prior to administration~~
         ~~3)~~**2)** Education of administering personnel regarding detection and monitoring of an adverse event
      iv. Monitoring
         1) Monitoring parameters
         2) Reporting mechanisms for adverse events
         3) Specific action to be taken if an adverse event occurs
      v. Education
         1) Information on any new Black Box~~ed~~ Warnings and action needed is updated in the computer~~, and~~ Pyxis systems and taken before the P&T committee to approve specific actions, guidelines or protocols.
      vi. Non-formulary Drugs with Black Box~~ed~~ Warnings
         1) ~~Tri-City Medical Center~~**TCHD** policy for non-formulary requests will be followed.
         2) All orders for non-formulary medications will be reviewed for Black Box~~ed~~ warnings.
      vii. Patient's Own Medications

1) ~~Tri-City Medical Center~~**TCHD** policy for patient's own medication will be followed.
2) As part of the review process all drugs will be reviewed for Black Box~~ed~~ warnings.

viii. Non-formulary Samples
1) Sample medications will not be permitted.
2) ~~Tri-City Medical Center~~**TCHD** Sample Policy will be followed.

3. Nursing shall review any additional interventions per alert to Black Box Warning drugs via Pyxis and/or the Cerner eMAR prior to administration. Additional information may be obtained, but is not limited to, the following:
a. Cerner reference text
b. Micromedex
c. ~~TCMC~~ **TCHD** Drug Formulary
d. Pharmacist

E. **RELATED DOCUMENTS~~ATTACHMENTS ON INTRANET UNDER CLINICAL REFERENCES~~:**
1. Black Box Warning ~~l~~List ~~rx 35.85.00-Ca~~

F. **REFERENCES:**
1. The Joint Commission Standard MM.01.01.03; MM.02.01.01
2. Healthcare Facilities Accreditation Program (HFAP) 25.01.19; 25.01.11
3. Centers for Medicare and Medicaid Services CMS Interpretation Guidelines CoP §482.25(a)(1)
4. Hospital Formulary System Policy ~~8390-200~~

Tri-City Medical Center
Oceanside, California

~~TELEMETRY~~
PATIENT CARE SERVICES

SUBJECT: MANAGEMENT OF ECG STRIPS

ISSUE DATE: New
REVISION DATE(S): New

Department Approval:	**02/17**
Clinical Policies and Procedures Committee:	**02/17**
Division of Cardiology Approval:	**04/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. Identify the process for posting/mounting electrocardiogram (ECG) strips in the medical record.
2. Identify the process for the delivery and posting (mounting) of ECG event strips in the medical record.

B. **DEFINITION(S):**
1. ECG Event Strips – Cardiac alarm ECG tracings printed manually or automatically
~~1.~~**2.** Central Monitoring Station - A centralized location for monitoring the following patient information: ECG tracings, vital signs (VSS) such as respiratory rate, blood pressure, oxygen saturation, invasive line numerical values.
~~2.~~**3.** Primary Registered Nurse (RN) – RN assigned as the direct patient care provider to a patient.
~~3.~~**4.** Cardiac Monitoring Units – Telemetry South Tower (2 East, 2 West, 4 East, 4 West) and Telemetry 3 Pavilion (3P).
5. Medical Monitored Unit – 4 Pavilion (4P) patients requiring heart rate monitoring.
~~4.~~**6.** **Monitored Strip Basket - A basket located on each Telemetry unit near the ECG monitor for the temporary placement of ECG strips.**

C. **POLICY:**
1. The Registered Nurse (RN) will review and interpret ECG strips printed during their shift as outlined in the Standards of Care, Adult or per department policies.
   a. RNs assigned to 4P are responsible for monitoring the heart rate of patients and are not responsible for interpreting ECG strips.
2. The primary RN assigned to nursing units or departments responsible for interpreting ECG strips are responsible for:
   a. Posting/mounting ECG strips in the medical record **placed in the ECG Holder, Monitor Strip basket, and delivered by an Unit Secretary (US) and ACT.**
   ~~a.~~**b.** **Reviewing ECG strips placed in the Monitor Strip basket during and prior to end of each shift.**
   ~~b.~~**c.** Ensuring the ECG mounting record is properly labeled with the patient's identification.
   ~~c.~~**d.** Units posting/mounting ECG strips on a Rhythm Strip Record will:
      i. Ensure a patient identification label is placed on the front and back of each Rhythm Strip Record.
      ii. Ensuring the patient name and medical record number (MRN) on the chart label, ECG strip(s) and Rhythm Strip Record are the same.

iii. Ensuring ECG strips are cut 6-7 inches to prevent strips from extending beyond the mounting space on the Rhythm Strip Record.
iv. ECG strips are posted/mounted in chronological order on the Rhythm Strip Record.
v. Reviewing printed ECG event strips occurring 2 hours prior to the start of the shift.
~~v.~~**vi. Discarding ECG strips that are not posted/mounted in the medical record per TCMC policy**.

3. ECG event strips printed or delivered to inpatient nursing units prior to the change of shift and during shift hand-off will be reviewed and posted / mounted on a Rhythm Strip Record by the on-coming RN.
   a. The on-coming RN is not responsible for interpreting the ECG event strip(s) occurring on the previous shift.
   b. Day shift RNs are responsible for posting ECG strips delivered to a unit after 6 am.
   c. Night shift RNs are responsible for posting ECG strips delivered to a unit after 6 pm.
4. Rapid Response and Code Blue ECG Strips will be cut 6-7 inches, posted/mounted in chronological order on a Rhythm Strip Record and placed in the medical record by the primary RN or designee.
5. Monitor Technicians will:
   a. **Print and** ~~C~~**c**ut ECG strips 6-7 inches.
   b. **Using patient identifiers,** ~~P~~**p**lace the ECG strips in chronological order and secure the ECG strips with a paper clip.
   c. Multiple patient ECG strips may be secured with a single paper clip.
   d. The clipped ECG strips may be stacked and then labeled with the floor's name.
   e. Deliver ECG strips to the Telemetry units ~~and 4P~~ during shift handoff. The ECG strips will be placed in the plastic strip holder located in the front of the medical record. The strip holder will be zipped to secure the ECG strips.
6. MT: Responsibility for 4P:
   a. Interpret ECG rhythms, document the rhythm per unit practice, and contact the RN per policy.
   b. Print ECG strips at the beginning of each shift. ECG strips may be printed prior to 0700 and 1900.
   c. The ECG strips will be delivered to 4P during shift hand-off.
   d. Contact a 4P staff to pick up:
      i. Admission and transfer ECG strips within 2 hours of the patient's arrival to 4P.
      ii. Rapid Response and Code Blue ECG strip as soon as possible.
7. Telemetry South Tower and 3P Rhythm Strip Delivery Process:
   a. Lift Team Technician (LLT) will:
      i. Pick up ECG strips from the MTs' central station every 3-4 hours between patient rounding times and as needed (PRN) as directed by a RN or when requested by a MT.
      ~~i.~~**ii. Place strips in the basket labeled Monitored Strip located near the ECG monitoring screen on the appropriate unit.**
      ~~ii.~~**iii.** ECG event strips shall be delivered to the Telemetry unit as outlined below:

ECG Event Strips Delivery	
MTs – Shift Hand-off (0700-0730 & 1900-1930) **Deliver ECG event strips not picked up by LTTs**	
Lift Team Technicians **Pick up ECG strips from the MT every 3-4 hours and PRN as requested by a RN or MT**	
End or Beginning of the shift times for both shifts	
0600-0730	**1800-1930**
LTTs Dayshift	**LTTs Nightshift**
1100	**2300**

1500	**0300**
1800	**0600**

b. Unit Secretaries (US) and Advanced Care Technicians (ACTs) will assist with delivering ECG strips as directed by a RN. The ECG strips will be delivered to the requesting RN.

c. ECG event strips requiring immediate attention e.g., a change in baseline ECG resulting in a Rapid Response or Code Blue notification, change or potential change in a patient's status, or identified by the primary RN/ Relief RN as requiring immediate attention:
   i. The primary RN/Relief Charge RN will delegate to a LTT, ACT, or US to pick up the ECG event strip(s) from the central monitoring station.
   ii. The ECG event strip(s) will be posted (mounted) on a Rhythm Strip Record by the primary RN during the shift the event(s) occurred.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**8/01**	**SUBJECT:**	**Medication Administration**
REVISION DATE:	**6/02; 1/03; 6/03; 12/03; 2/04, 3/05; 3/06; 4/07; 3/08; 9/08; 04/09; 3/10, 1/11, 7/11, 4/12; 02/14; 12/15**	**POLICY NUMBER:**	**IV.I**

Department Approval:	**03/17**
Clinical Policies & Procedures Committee Approval:	**~~08/15~~03/17**
Nursing Executive Council Approval:	**~~09/15~~03/17**
Pharmacy & Therapeutics Committee Approval	**~~09/15~~05/17**
Medical Executive Committee Approval:	**~~10/15~~06/17**
Professional Affairs Committee Approval:	**~~11/15~~07/17**
Board of Directors Approval:	**12/15**

A. **DEFINITION(S):**

1. Titrating Orders – orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services (PCS) Titrating Medications Policy.
2. Taper Orders – orders in which the dose is decreased by a specified amount with each dosing interval.
3. Indefinite Hold Medication Order – order for discontinuation of the medication (refer to PCS Automatic Stop Orders Policy).
4. Barcode medication administrator (BCMA) device [point of care (POC)] Solution designed to support positive patient identification using bar code technology. It is based on Cerner Millennium® Mobile technology and is deployed using hand-held devices with integrated bar code scanners.
5. Scheduled medications include all maintenance doses administered according to Tri-City Medical Center (TCMC) medication administration timeframes (e.g., QID, TID, BID, daily, weekly, monthly, and annually). Scheduled medications do not include:
   a. STAT AND Now doses
   b. First doses and loading doses
   c. One-time doses
   d. Specifically timed doses (e.g., antibiotic for surgical patient to be given a specified amount of time before incision, drug desensitization protocols)
   e. On-call doses (e.g., pre-procedure sedation)
   f. Time-sequenced or concomitant medications (e.g., chemotherapy and rescue agents, n-acetylcysteine and iodinated contract media)
   g. Drugs administered at specific times to ensure accurate peak/trough/serum drug levels.
   h. Investigation drugs in clinical trials.
   i. PRN medications.
6. STAT-medications to be given as soon as possible and within 30 minutes of availability of the medications.
7. Time-critical scheduled medications are those where early or delayed administration of maintenance doses of greater than 30 minutes before or after the scheduled dose may cause harm or result in substantial sub-optimal therapy of pharmacological effect. Examples of time-critical medications/medication types may include, but are not limited to:
   a. Antibiotics
   b. Anticoagulants
   c. Insulin
   d. Anticonvulsants
   e. Immunosuppressive agents

f. Pain medication
g. Medications prescribed for administration within a specified period of time of the medication order
h. Medications that must be administered apart from other medications for optimal therapeutic effect (i.e. ciprofloxacin and multivitamin)
i. Medications prescribed more frequently than every 4 hours

8. Non-time-critical scheduled medications are those where early or delayed administration within a specified range of 1 hour should not cause harm or result in substantial sub-optimal therapy or pharmacological effect.
9. Controlled Substance: is a drug, compound, mixture, preparation or substance included in Schedule II, III, IV, or V.

B. **POLICY:**

1. Medication Order Process
   a. Medications shall be administered only upon the order of medical staff members or allied health professionals who have been granted clinical privileges to write such orders under the guidelines of their respective scopes of practice.
      i. Medications shall be administered according to the guidelines set forth in Administering Medication per Scope of Practice.
      ii. See PCS Physician/Provider Orders Policy for information on ordering medication including telephone/verbal orders and PRN medications.
   b. Medication orders shall be reviewed by pharmacists before administration by a licensed healthcare provider, unless a physician is overseeing administration of the medication, i.e. "Non-Profile" Pyxis areas.
      i. See Pharmacy Unlabeled Uses of FDA Approved Medications Policy for information on additional information on unlabeled use of medications
   c. Registered Nurses (RN) shall verify all new medication orders for accuracy using Nurse Review each time an order is added to the Electronic Medication Administration Record (eMAR) by the pharmacist per PCS Physician/Provider Orders Policy. The paper MAR is to be used ONLY if the eMAR is unavailable to staff.
      i. Respiratory Care Practitioners may conduct medication review for all nebulized and inhaled medications if the RN has not completed Nurse Review and one of the above medications is due for administration.
      ii. Under the supervision of a physician, physician assistant, or other appropriate licensed person, medical assistants in an outpatient setting may administer medications, except controlled substances, in several ways to a patient, including simple injections, ingestion or pre-measured medications.
      iii. Medical assistants who receive the appropriate training are allowed to administer injections of scheduled drugs only if the dosage is verified and the injection is intramuscular, intradermal or subcutaneous. The supervising physician or physician assistant must be on the premises as required in section 2069 of the Business and Professions Code, except as provided in subdivision (a) of that section. However, this does not include the administration of any anesthetic agent.
   d. A nurse may obtain medications not yet reviewed by a Pharmacist through the Pyxis override function only if need is deemed urgent or emergent.
      i. Urgent indications include those in which significant patient harm could result from a delay secondary to a pharmacist's review of the order.
      ii. Emergent indications include situations in which life, limb, or eyesight is threatened.
      iii. In each individual case, the need for the override must outweigh the risk of omitting the pharmacist's review of the order.
   e. If orders are received with more than one set of ranges (dose and frequency), then the healthcare professional must clarify the order with the physician.

i. If clarification is not obtained before the dose is needed, the RN shall implement range orders at the smallest ordered dose and the longest time interval between doses, if repeated dosing would be required. However, if the patient assessment indicates a clinical need for more aggressive intervention, then the individual implementing the range-dosed medication may initiate treatment at a higher dosage or administer the medication at the more frequent time interval within the parameters of the order.

ii. Adjustments within the dose range are based on:
1) Patient assessment
2) Prior dose administered
3) Time interval between doses
4) Effectiveness of prior doses

f. The RN shall assess the patient and if therapy is not meeting clinical needs or desired response, the physician shall be contacted for dosage and/or frequency adjustment.

g. All continuous infusions of controlled substances shall have the medication in a secured device (for example lock box or locked infusion pump).

2. Medication Administration Process

a. The Electronic Medication Administration Record (eMAR) or paper MAR shall be evaluated at the beginning of each shift and PRN to:

i. Verify medications to be administered during the shift.

ii. Review and document review of allergies in the medical record.

~~iii. Medication orders shall be reviewed by pharmacists before administration by a licensed healthcare provider, unless a physician is overseeing administration of the medication, i.e. "Non-Profile" Pyxis areas or the medication is deemed is urgent or emergent.~~

~~iv.~~**iii.** Conduct Nurse Review (RN Sign-off) on any medications that have not yet been reviewed (identified with the icon of Eyeglasses) per PCS Physician/Provider Orders Policy.

b. Once BCMA application on hand-held devices is implemented, the departments shall use BCMA for medication administration.

c. Medications brought from home may be administered only on the order of a physician per PCS Medication Brought in by Patient Policy.

i. A pharmacist shall positively identify the medication, ~~initial the "Medication Checked by Pharmacy" label, and affix,~~ **print and initial a patient-specific medication label, and affix** it to the medication container.

d. Prior to administration of ~~subcutaneous insulin or~~ heparin, the amount ordered and prepared shall be verified by a 2nd RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.

i. Identification of the patient shall take place in the patient's room

ii. Behavioral Health Unit will not be required to validate in patient's room due to safety issues

iii. Document first and last name and title of second practitioner who verified the medication via BCMA device or electronic medical record.

e. Prior to administration of intravenous insulin, heparin, ~~,~~ 10% magnesium sulfate, tissue plasminogen activator (tPA) and patient controlled analgesia (PCA), or any medication given through an epidural, the amount ordered, amount prepared, initial infusion rate, and any changes in infusion rate shall be verified by a second RN or licensed practitioner per PCS Medication High Risk/High Alert Policy.

i. Validation process shall take place in the patient's room.

ii. Document initiation and dose changes on eMAR/paper MAR. Document first and last name and title of second practitioner who verified under the comments section.
1) Document epidural/PCA assessment in IView.

f. For maximum amounts of solution to be administered intramuscularly in one site see Intramuscular Administration Amount per Site.

g. Medication shall be administered immediately by the licensed healthcare provider withdrawing the medication from an ampule or vial. If not administered immediately by the licensed staff, syringe must be labeled appropriately.
   i. Non-controlled - medications shall be withdrawn from a single dose vial at bedside.
   ii. Controlled Medication – requiring waste upon removal shall be performed according to PCS Controlled Substance (Narcotics) Management Policy and PCS Wasting Narcotics via Pyxis Machine Procedure.

h. Medication from ampules shall be prepared and labeled appropriately prior to entering patient room.

i. Medication from multi-dose vials shall be prepared and labeled appropriately prior to entering patient room or operating room.
   i. Only vials clearly labeled by the manufacturer for multiple dose use can be used more than once.
   ii. Limit use of a multi-dose vials to a single patient whenever possible.
   iii. Multi-dose medications used for more than one patient are stored and accessed away from the immediate areas where direct patient contact occurs.
   iv. If a multi-dose vial is taken into a patient room/operating room, it can only be used for that patient and must be discarded after use.
   v. When multiple dose vials are used more than once, use a new needle and new syringe for each entry.
   vi. Disinfect the vial's rubber septum before piercing by wiping (using friction) with an approved antiseptic swab. Allow the septum to dry before inserting a needle or other device into the vial.
   vii. All multi-dose vials once opened or punctured, shall be labeled with an expiration date of 28 days or the manufacturer's date or **package**~~packet~~ insert recommendations, whichever is shorter.

j. Label all medications, medication containers (i.e., syringes, medicine cups, basins), or other solutions on and off the sterile field in perioperative and other procedural settings. Refer to PCS Labeling Medication On and Off the Sterile Field Procedure.

k. Never administer medications from the same syringe to more than one patient, even if the needle is changed or you are injecting through an intervening length of IV tubing.

l. Do not enter a medication vial, bag, or bottle with a used syringe or needle.

m. Never use medications packaged as single-dose or single-use for more than one patient. This includes ampules, insulin pens, bags, and bottles of intravenous solutions, and sterile water bottles.
   i. Use a single-dose/single-use vial for a single patient during the course of a single procedure
   ii. Discard the vial after this single use, used vials should never be returned to stock on clinical units, drug carts, anesthesia carts etc.
   iii. If a single dose/single use vial must be entered more than once during a single procedure for a single patient to achieve safe and accurate titration of dosage, use a new needle and new syringe for each entry
   iv. Select the smallest vial necessary when making treatment decisions to reduce waste

n. Always use aseptic technique when preparing and administering injections.

o. For patients age 13 years and younger, the maximum IV solution volume for administration is 500 mL.

p. Educate the patient/family/significant other according to comprehension level. Education should include:
   i. Drug name
   ii. Dose
   iii. Purpose
   iv. Ask if they have any questions/concerns about taking the medication especially new or first time medications.

v. Side effects of medications.
1) Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
vi. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
vii. Document all teaching on the Education – All Topics Form.

q. Discuss any unresolved, significant patient/family concerns about the medication with the patient's physician, prescriber (if different from the physician), and/or relevant staff involved with the patient's care, treatment, and services. Document in the medical record.

r. The licensed healthcare provider shall accurately document medication at the time of administration.

s. Scheduled medications shall be administered within 1 hour prior to the order time and 1 hour after the order time.

t. If a medication cannot be given at the time ordered, the appropriate reason shall be documented on the eMAR/paper MAR.

u. When administering medications from a standardized procedure, the health care provider shall enter the order electronically ~~or document the title of the standardized procedure used and the name and dose of the medication administered on the physician's order sheet. This order shall be scanned to pharmacy.~~
~~i. Sample order entry: "Standardized Procedure: Hypoglycemia Management, glucagon 1 mg IM times one."~~
~~ii.~~i. Exception: Orders generated by screening in Cerner

v. If a medication is not administered or used, it shall be returned ~~or~~, wasted within 1 hour or at the end of procedure per Patient Care Services Controlled Substance (Narcotics) Management Policy.

3. Self Administration/Non-Staff
a. Persons who administer medications, but are not staff members (including the patient if self-administering), must demonstrate ability to safely administer medication before being allowed to self-administer medications. This includes understanding medication name, type, reason for use, how to administer medication (including process, time, frequency route and dose) and anticipated action/side effects of medication administered
i. If they cannot demonstrate the ability to safely administer medications:
1) They will not be able to self-administer until the ability is demonstrated.
2) Licensed healthcare providers will provide teaching using Tri-City Medical Center approved drug leaflets, handbooks, videos, lectures, demonstration, and equipment to all patients (parents, significant others) to prepare them for successful self-medication.
3) Discharge planning shall include a follow-up plan as needed.

4. Monitoring Effects of Medications on Patients
a. Effects of medications on patients are monitored to assess the effectiveness of medication therapy and to minimize the occurrence of adverse events.
i. Each patient's response to medication administered is monitored according to his or her clinical needs.
ii. Ongoing patient medication monitoring will use a collaborative approach between patient care providers, physician, pharmacists and the patient, family or caregiver.
b. Monitoring will address the patient's response to the prescribed medication and actual or potential medication-related problems.
c. The results of patient medication monitoring will be used to improve the patient's medication regimen and/or other clinical care and treatment processes.
i. The physician/Allied Health Professional will be notified if the medication therapy is not achieving the desired effect.

5. Medication Handling, Storage, and Disposal

a. All medications received from the pharmacy shall be placed in approved storage areas as soon as possible, not to exceed 30 minutes from the time of receipt.
b. Any medication removed from the medication storage area:
    i. Shall remain with the individual at all times and shall not be left unattended including flushes and vials.
    ii. Shall not be left on or in any area exceeding 80°F. This includes the pockets of the healthcare provider.
    iii. No medications, including flushes and vials, shall be left at the bedside.
        1) **Exception: Appropriately labeled topical ointments, creams, or pads as approved by the Pharmacy and Therapeutics Committee and ordered for bedside storage by the physician/Allied Health Professional**
c. Access to medications and syringes are limited to appropriate staff via locked or computerized controlled access.
d. In all inpatient areas, insulin pens, creams, inhalers, eye drops and other medications that are not stored in the Pyxis medication station must be kept in patient-specific bins in a locked cabinet in the medication area.
    i. The primary nurse will be responsible for transferring these medications when a patient is transferred to another unit or room.
    ii. The primary nurse will be responsible for returning un-used medications or disposing of opened medications when a patient is discharged from the hospital.
    iii. The primary nurse must clean the medication bin with a sani-wipe after patient transferred or discharged.
e. A device holder will be used when administering a medication from a pre-filled syringe.
f. Any intravenous solutions spiked outside of a laminar flow hood must be initiated/administration started within 1 hour of being spiked.
g. Nursing personnel shall only compound or admix when not feasible for pharmacy to do so (i.e. emergency or product stability is short). Refer to Patient Care Services procedure *Admixture, Intravenous*). Medication preparation is performed by using aseptic technique as appropriate in a clean, uncluttered, functionally separate area, to minimize the possibility of contamination.
h. Unused/Intact Medication removed from the Medication Pyxis and not administered shall be returned to the Pyxis "Return Bin" with the exception of refrigerated and some designated controlled substance medication.
    i. For non-controlled medications that are too large, place into the red external "Return to Pharmacy" bin.
    ii. For controlled substances that are too large to be returned to the Medication Pyxis, contact pharmacy for assistance.
i. At discharge, unused intact medications shall be returned to the pharmacy.
j. For proper disposal of pharmaceutical waste,
    i. See Administrative Policy #276 Handling of Pharmaceutical Waste, Expired Medications, and Expired IV Solutions.
    ii. See the Patient Care Services procedure Hazardous Drugs for hazardous drug disposal and waste.
k. Patient specific medications maybe delivered by TCMC personnel as designated per Pharmacy.

6. Medication Error/Near Miss Reporting – see Administrative Policy Incident Report - Quality Review Report (QRR) RL Solutions Policy Number 8610-396

C. **PROCEDURE:**

1. For Departments Using BCMA:
    a. Prior to administering a medication, the licensed healthcare provider shall:
        i. Verify correct patient
            1) Use two patient identifiers (see PCS Identification, Patient Policy)
        ii. Verify medications due per eMAR

1) Verify RN review completed, no eyeglasses icon, in all areas (except ED)
2) Review allergies to make sure all information is current and correct before administration of any medications.
3) Review for any contraindication(s) for administering medication

a. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   i. Verify correct dose, route and time
   ii. Verify expiration date on medication package
   iii. Visually inspect medication integrity (i.e., discoloration, particulates, turbidity when a medication should be clear) or torn packaging may be signs of medication deterioration
   iv. Take all medication in their original packages into patient room to be scanned. When any medication is removed from package for mixing, crushing, or splitting, the package must be taken into patient room.
      1) Medications shall be crushed and administered separately.
      2) Crusher shall be cleaned after each crush if medication cups are not used inside of crusher.
      3) Pill splitter shall be cleaned after each use
b. Retrieve hand-held device from the unit specific secure hand-held device storage area.
c. Scan the "Aztec" barcode on the patient ID band to ensure the right patient record is opened on the BCMA application.
d. If a patient ID band does not scan, the licensed healthcare provider may replace the patient ID band, or manually search for the patient on the hand-held device using the patient identifiers on the patient ID band. Scan each medication with the hand-held device to ensure additional medication "rights" for mistake free medication are identified.
   i. Verify correct:
      1) Patient
      2) Dose
      3) Time
      4) Medication
      5) Route/ Rate (if applicable)
      6) Documentation
      7) Reason
e. Assess and resolve any warning message(s).

2. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
3. Administer medications after the medications are scanned and all "rights" are assured to be accurate.
   a. STAT or one-time medications shall be given as soon as they are available and the exact time given shall be documented.
   b. The licensed health care provider administering oral medication shall remain with the patient until the medication is successfully administered.
4. Sign the medications on the hand-held device after the medication is given and/or successfully administered. Comments may be added as required.
   a. The BCMA application will automatically update the Cerner system (eMAR) with the data entered.

D. **For Departments Not Using BCMA:**

1. Prior to administering a medication, the licensed healthcare provider shall:
   a. Verify correct patient
      i. Use two patient identifiers (see PCS Identification, Patient Policy)
   b. Verify medications due per eMAR
      i. Verify RN review completed, no eyeglasses icon, in all areas (except ED)
      ii. Review allergies and/or contraindication(s) for administering medication
2. Prepare medications for one patient at a time with the patient's current, updated eMAR for accuracy.
   a. Verify correct dose, route and time
   b. Verify expiration date on medication package
   c. Visually inspect medication integrity (i.e., discoloration, particulates, and turbidity when a medication should be clear) or torn packaging may be a sign the medication deterioration
   d. Medication may be withdrawn from vial at bedside and shall be administered immediately. If medicine is prepared in the Medication room – the syringe must be labeled appropriately.
   e. The medication "rights" are identified before the medication is administered. Verify the following are correct:
      i. Patient
      ii. Dose
      iii. Time
      iv. Medication
      v. Route/ Rate (if applicable)
      vi. Documentation
      vii. Reason
   f. Medications shall be crushed and administered separately. Crusher shall be cleaned after each crush if medication cups are not used inside the device.
3. Educate the patient/family/significant other and address any unresolved concerns about the medication.
   a. Name of the drug, the dose, and the purpose according to the patient's ability to comprehend.
   b. Side effects of medications.
      i. Adverse drug reactions or side effects may occur with the first dose or any subsequent dose.
   c. Licensed healthcare providers shall provide teaching materials (drug leaflets, handbooks, videos, lectures, demonstration, and equipment) to all patients (parents, significant others) to prepare them for successful self-medication.
   d. Document all teaching on the Education – All Topics Form.
4. Administer medications after all "rights" are assured
5. The licensed health care provider administering oral medication must remain with the patient until the medication is successfully administered.
6. The licensed healthcare provider shall then accurately document medication administration in the eMAR or paper MAR as soon as possible after the dose is given.

E. **OUTPATIENTS:**

1. Any medication brought to the hospital by a patient who is to receive outpatient testing is the sole responsibility of the patient.
2. The hospital shall not administer nor handle any medications brought into the facility by patients for outpatient testing.

F. **CHEMOTHERAPY ADMINISTRATION:**

1. Chemotherapeutic agents shall be administered by TCMC chemotherapy credentialed RNs per the Oncology Chemotherapy Administration.

2. Notify pharmacy and oncology unit if chemotherapeutic agents are to be administered in areas other than dedicated chemotherapy area.

G. **HAZARDOUS DRUGS, HANDLING OF:**

1. See PCS Hazardous Drugs Procedure

~~H. FORMS (LOCATED IN PATIENT CARE SERVICES MANUAL; FORM / RELATED DOCUMENTS FOLDER):~~

~~1. Medication: Administering Medication per Scope of Practice~~
~~2. Medication Administration Time Frames~~
~~3. Medication: Intramuscular Administration Amount per Site~~

~~I.~~**H. RELATED DOCUMENTS:**

1. Administrative Policy: Incident Report - Quality Review Report (QRR) RL Solutions – 8610-396
2. **Medication: Administering Medication per Scope of Practice**
3. **Medication Administration Time Frames**
4. **Medication: Intramuscular Administration Amount per Site**
5. Oncology Chemotherapy Administration
~~2.~~6. **PCS Procedure: Admixture, Intravenous**
~~3.~~7. PCS **Policy:** Automatic Stop Orders ~~Policy~~
~~4.~~8. PCS **Policy:** Controlled Substance (Narcotics) Management ~~Policy~~
~~5.~~9. PCS **Procedure:** Hazardous Drugs ~~Procedure~~
~~6.~~10. PCS **Policy:** Identification, Patient ~~Policy~~
~~7.~~11. PCS **Procedure:** Labeling Medication On and Off the Sterile Field ~~Procedure~~
~~8.~~12. PCS **Policy:** Medication Brought in by Patient ~~Policy~~
~~9.~~13. PCS **Policy:** Medication High Risk/High Alert ~~Policy~~
~~10.~~14. PCS **Policy:** Physician/Provider Orders ~~Policy~~
~~11.~~15. PCS **Policy:** Titrating Medications ~~Policy~~
~~12.~~16. PCS **Procedure:** Wasting Narcotics via Pyxis Machine ~~Procedure~~
~~13.~~17. Pharmacy **Policy:** Unlabeled Uses of FDA-Approved Medications ~~Policy~~

Administering Medication per Scope of Practice

X indicates who may administer	IV	IV PUSH	IVPB	PO	SQ	IM	SL	Intra-dermal	Topical	Inhalant Aerosol
RN	X	X	X	X	X	X	X	X	X	X
LVN I/Licensed Psychiatric Technician				X	X	X	X	X	X	X
LVN II (IV-certified) May only administer electrolytes, vitamins, nutrients, blood, and blood products	X			X	X	X	X	X	X	X
Respiratory Care Practitioners								X		X
Physical Therapist									X	
Licensed Physical Therapy Assistant									X	
Radiologic Technologists under physician guidance*	X			X						
Nuclear Med Technician*	X									
EKG/Echo Tech under direct supervision of physician as part of EKG/Echo procedure							X			
Medical Technicians								X		
Student RCP under supervision										X
Medical Assistants				X	X	X	X	X	X	

*Only RN's may administer IV mediations via PICC and central lines.

Medication Administration Time Frames

Daily	-	0900
qam	-	0900
qhs	-	2100
bid	-	0900 - 2100
tid	-	0900 - 1500 - 2100
qid	-	0900 - 1300 - 1700 - 2100
q4h	-	0100 - 0500 - 0900 - 1300 - 1700 - 2100
q6h	-	0600 - 1200 - 1800 - 2400
q8h	-	0500 - 1300 - 2100
q12h	-	0900 - 2100

Specific Medications:
~~Coumadin~~ **Warfarin** - 1700
Standard capillary blood glucose checks AC and HS - 0800, 1130, 1730, and 2100
Standard capillary blood glucose checks every 6 hours - 0600, 1200, 1800, and 2400
Lithium - 2000
Digoxin - 1200
Diuretics - 0900 - 1700 (ordered BID)
Medications ordered with meals shall be given according to tray delivery times.
Respiratory medications shall be given per unit specific policy.
Bupropion, Venlafaxine, Modafinil, Methylphenidate: if ordered BID 09:00 and 14:00

In addition to the above standard administration times, the pharmacist shall designate the appropriate administration time for certain medications to optimize drug therapy. Some examples are as follows:
Proton Pump Inhibitors – BID 0600 – 2100
~~"~~Statins~~"~~ – Daily 2100
Carafates – Q6 2400 – 0600 – 1100 – 1600

Intramuscular Administration Amount per Site

Age group (years)	Needle Length-max	Needle gauge	Volume-Max	Site(s)
Infant (0-1.5)	5/8 inch	25-27	0.5-1 mL: infant less than 1500 gm, maximum 0.5 mL	• Vastus lateralis • Rectus femoris
Toddler/ Preschool (1.5-3)	1 inch	22-23	1 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal (for children who has been walking for at least one year)
Preschool (3-6)	1 inch	22-23	Deltoid: 0.5 mL All other sites: 1.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal (for children who have been walking for several years) • Deltoid (for children over 4 – 5 years of age due to small muscle mass)
School Age (6-15)	1-1 ½ inch	22-23	Deltoid: 0.5 mL All other sites: 1.5-2.0 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adolescent (up to 21)	1-1 ½ inch	22-23	Deltoid: 1 mL All other sites: 2-2.5 mL	• Vastus lateralis • Rectus femoris • Dorsogluteal • Ventrogluteal • Deltoid
Adults	1-1 ½ inch	22-27(for aqueous solutions) 18-25 (for viscous or oil-based medications)	3 mL	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY ~~MANUAL~~

ISSUE DATE: 12/01	**SUBJECT: Patient and Family Education**
REVISION DATE: 06/03, 04/06, 10/07, 02/09, 06/11	**POLICY NUMBER: V.A**

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**~~07/14~~05/17**
Nursing Executive Committee Approval:	**~~07/14~~05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~08/14~~07/17**
Board of Directors Approval:	**08/14**

A. **PURPOSE:**

1. To ensure every patient is provided with the necessary information to address individual health needs and challenges.

B. **DEFINITIONS:**

1. **Patient** – refers to patient, family, caregiver, and significant other(s) who may benefit from patient education.

C. **POLICY:**

1. Healthcare providers shall ensure the patient receives education and training specific to the patient's needs and abilities and as appropriate to the care, treatment, and services provided.
2. All patient and family education shall be documented in the Electronic Health Record (EHR)
3. Healthcare providers shall support the provision and coordination of patient education activities and identify and provide the resources necessary for achieving educational objectives.
4. Tri-City ~~Medical Center~~**Healthcare District** (TC**HD**~~MC~~) shall provide all patients with basic safety related information at the time of admission to TCMC.
5. All patient care providers participate in patient education in the course of daily patient care.
6. Patient education is a collaborative process that promotes independence and self care.
   a. All patients are entitled to information that helps them better understand and cope with their medical condition and treatment plan.
   b. Education enables the patient to resolve health problems, make informed decisions, and institute healthy behaviors.
7. Education provided is based on the patient's assessed needs.
8. The assessment of learning needs addresses age, cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, barriers to communication, literacy, living environment, previous experience and resource availability as appropriate.
9. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following:
   a. Plan for care, treatment, and services
   b. Basic health practices and safety
   c. Safe and effective use of medications
   d. Food-drug interactions
   e. Nutrition interventions, modified diets, or oral health
   f. Safe and effective use of medical equipment or supplies when provided by the hospital

g. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
h. Rehabilitation techniques to help them reach the maximum independence possible
i. Infection prevention measures
j. Measures taken to prevent adverse events in surgery
k. Community resources and when necessary, how to obtain further care, services, or treatment to meet identified needs
l. Appropriate information about patient responsibilities and self-care activities
m. Discharge instructions to the patient and those responsible for providing continuing care
n. Information on oral health
o. Fall reduction strategies

10. Patients receive education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided.
    a. Education is coordinated among the disciplines providing care, treatment, and services.
    b. The content is presented in an understandable manner.
    c. Teaching methods include verbal discussion, written materials, electronic carenotes, demonstration and videos.
    d. Teaching methods accommodate various learning styles and readiness to learn
    e. Patient education is documented in the EHR
        i. Assessment of learning needs
        ii. Interventions to meet those needs
        iii. Patient response to education
        iv. Educational materials provided
    f. Comprehension is evaluated and documented
11. Patients receive education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

Tri-City Health Care District
Oceanside, California

Patient Care Services ~~Clinical Policy Manual~~

ISSUE DATE:	**07/97**	**SUBJECT:**	**Patient Rights & Responsibilities**
REVISION DATE:	**04/00; 05/02; 12/02; 12/03; 01/06; 05/07; 07/08; 02/09; 02/11; 06/14**	**POLICY NUMBER:**	**8610-302**

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**~~06/14~~03/17**
Nurse Executive Committee Approval:	**~~06/14~~03/17~~05~~/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**~~07/14~~07/17**
Board of Directors Approval:	**08/14**

A. **PURPOSE:**

1. To describe Tri-City Healthcare District's (TCHD) process of informing patients of their rights and responsibilities while receiving care, treatment, or services.
   a. To ensure TCHD staff are aware of and their conduct supports patient's rights.
   b. To set forth behavioral guidelines for patients and families to ensure safe delivery of care, treatment, and services.

B. **DEFINITION(S):**

1. Patient Rights: A standard belief that patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial, and spiritual values. These values often influence the patient's perceptions and needs. By understanding and respecting these values, providers can meet care, treatment, and service preferences.

C. **POLICY:**

1. TCHD facilitates the fulfillment of patient's responsibilities by ensuring that each patient, as appropriate to his/her condition, is a partner in the healthcare process.
2. Care is provided in a manner that respects and fosters dignity, autonomy, positive self-image, cultural values, and involvement in care decisions.
3. Care is individualized to incorporate cultural, psychosocial, and spiritual values.
4. Upon admission, each patient is given a copy of the Patient's Bill of Rights and Patient Responsibilities located in the Patient Guide.
   a. The Patient's Bill of Rights is also printed on the TCHD Conditions of Admissions Form and is acknowledged by the patient's signature.
5. The "Patient's Bill of Rights" is posted (in both English and Spanish) in each patient care area and Registration.

D. **RELATED DOCUMENT(S):**

1. **Behavior Health Services Policy: Patient Rights**
2. **Conditions of Admission – Sample**
3. **Justice Involved Patient's Rights and Responsibilities – Sample**
4. **Patient Rights Poster - Sample**

E. **REFERENCE(S):**

1. **California Hospital Association Consent Manual 2017**

Conditions of Admission – Sample

CONDITIONS OF ADMISSION

1. CONSENT TO HOSPITAL PROCEDURES: The patient consents to the medical and surgical procedure, which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services. These may include but are not limited to laboratory tests, x-ray examinations, medical or surgical treatment or procedures, anesthesia, photographic/video records or hospital services rendered to the patient under the general and special instructions of the physician or surgeon. The attending physician must verbally inform the patient that telehealth may be used, and obtain verbal consent from the patient for this use. The verbal consent must be documented within the patient's medical record by the attending physician. The exception for this consent is for any patient that is under the jurisdiction of the Department of Corrections or any other correctional facility.

   The patient consents to the taking of pictures of his/her medical or surgical condition or treatment, and the use of the pictures for purposes of diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

2. CONSENT TO BLOOD TESTING: In the event of an exposure of blood or body fluids to a health care worker, I acknowledge that the patient's blood will be tested for bloodborne viruses including Human Immunodeficiency Virus (HIV). The results of the test are necessary to determine whether the exposed health care worker needs immediate preventive treatment. The physician will inform the patient of the accidental exposure, test completion and results. _____Initials

3. NURSING CARE: The patient understands that this hospital provides only general duty nursing unless, upon orders of the physician, the patient is provided more intensive nursing care. If the patient's condition requires a special duty nurse, the patient agrees that it must be arranged by the patient or their legal representative. The hospital will not be responsible for failure to provide the same and is released from any liability arising there from.

4. TRAINING AND EDUCATION: The hospital participates in the training of residents, medical students, students nurses and other healthcare personnel. I agree that they may participate in my care to the extend deemed appropriate by the Medical Staff or Hospital personnel, and I consent to the demonstration, observation and administration of treatment or procedures by such persons under the supervision of the members of the Medical Staff or Hospital personnel.

5. MEDICATIONS: The patient understands and agrees not to bring any medications (including non-prescription, prescription, and herbals) into the hospital. This applies to both inpatient and outpatient services. Patient agrees to provide hospital with a list of all medications (including non-prescription, prescription and herbals) that he/she is currently taking. _____Initials

6. PERSONAL VALUABLES: The patient understands and agrees that the hospital maintains a safe for the safekeeping of money and other valuables, and that the hospital shall not be liable for the loss of such valuables unless they are deposited with the hospital for safekeeping. Liability of the hospital for loss or damage is limited by statute to five hundred dollars. The patient understand that he/she is responsible for personal effects, including personal grooming articles, jewelry, clothing, documents, medication, eye glasses, hearing aids, dentures and other prosthetic devices. _____Initials

7. NON-SMOKING HOSPITAL: The patient understands that no smoking is permitted within the hospital except in designated places.

8. PATIENT RIGHTS AND RESPONSIBILITIES: The hospital retains a patient representative who the patient may contact regarding concerns about care and treatment. The patient/agent has received a copy of Patient Rights and Responsibilities. _____Initials

9. RELEASE OF INFORMATION: To obtain payment for service, the patient/agent authorizes the hospital/provider to disclose to the patient's insurance carrier, health service plan, workers compensation carrier, or rendering physician any and all medical and basic information including name, location and general condition. If the patient doesn't want such information released, he/she may make a written request for such information to be withheld. A separate form is available for this purpose upon request. How Tri-City Medical Center may further use or disclose patient identifiable medical information about you, including disclosures for purposes of treatment, payment and health care operations is described in the Notice of Privacy Practice. The undersigned acknowledges having been offered a copy of the Notice and may request an additional copy at this time or access at www.tricitymed.org. _____Initials

10. I authorize TRI-CITY MEDICAL CENTER, its service providers (including service providers contacting me about obtaining financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

11. FINANCIAL AGREEMENT: It is agreed, whether signed as agent or patient, that in consideration of the services to be rendered to the patient he/she individually obligates him/herself to pay the account of the hospital in accordance with regular rates and terms of the hospital including its financial assistance policies. Should the account be referred to an attorney or collection agency for collections, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

12. ASSIGNMENT OF BENEFITS: The patient or agent, hereby authorizes direct payment to the hospital/provider, any insurance benefits, including but not limited to third party liability payable to or on the patient's behalf for this hospitalization or for these services, including emergency services if rendered, at a rate not to exceed the hospital's billed charges. It is agreed that payment to the hospital by an insurance company shall discharge the insurance company of all obligations under a policy to the extent of such payment.

The patient understands that he/she is financially responsible for charges not covered by this assignment. This assignment is irrevocable.

13. PHYSICIANS ARE INDEPENDENT CONTRACTORS: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, the emergency department physician and the like, are independent contractors and are not employees or agents of the hospital. Some of these physicians will bill separately for their services and may not have agreements with same insurance plans as the hospital. The undersigned acknowledges receipt of the Patient Notification Form and may request an additional copy at this time. _____ Initials

    The patient is under the care of and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

14. HEALTH PLAN OBLIGATION: This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from Patient Financial Services. The hospital has no contract, express or implied with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all covered services rendered to him/her by the hospital if he/she belongs to a plan, which does not appear on the above-mentioned list.

    The undersigned certifies that he/she has read the foregoing, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

15. VISITORS: You have the right to visitors of your choice, including spouse, domestic partner (including same sex domestic partners), another family member or a friend.

_____ _____ ___/___/___ ___:___ AM/PM

Name: Patient/Legal Representative | Signature: Patient/Legal Representative | Date (m/d/y) | Time

If signed by other than patient, indicate relationship:

☐ Parent ☐ Spouse ☐ Partner ☐ Relative _____ ☐ Conservator ☐ Tutor/Legal Guardian

If patient is unable to sign, state reason: _____

☐ Interpretation provided: Language: _____

☐ Telephonic ☐ VRI _____

Interpreter: Name or ID No.

☐ Face-to-face interpreter Signature: _____

_____ _____

Witness/Representative of Tri-City Medical Center (print name) | Signature

Financial Responsibility Agreement by Person Other Than the Patient or Patient's Legal Representative.

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits and Health Plan Obligation provisions above.

Signature: _____ _____

(Financially responsible party) *(print name)*

Date/Time: _____

Witness: _____ _____

(TCMC representative) *(print name)*

Date/Time: _____

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

8560-4011
(Rev. 6/15)

CONDITIONS OF ADMISSION

Affix Patient Label

Justice Involved Patient's Rights and Responsibilities – Sample

JUSTICE INVOLVED PATIENT'S RIGHTS & RESPONSIBILITIES

A patient's rights and responsibilities shall include but not be limited to:
(a patient shall have the right to:)

1. Exercise these rights without regard to sex or culture, economic, educational, or religious background or the source of payment for care.
2. Considerate and respectful care, including privacy in treatment and in care of personal needs, when not in conflict with security and custodial policies.
3. Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand and to be afforded the opportunity to discuss medical treatment.
4. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each.
5. Participate in the consideration of ethical issues that arise in the provisions of the patient's care. A Bio-Ethics Committee exists for the purpose of addressing ethical issues which may arise the care of the patient. To gain access to the Bio-Ethics Committee, please notify the unit charge nurse or nursing administrator.
6. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with the care or who is outside the correctional treatment center, except in case of transfer to another health care facility, or as or required by law.
7. Reasonable responses to any reasonable requests made for services.
8. To give informed consent or to refuse any treatment or procedure or participation in experimental research.
9. Be informed of continuing health care requirements following discharge from the hospital.
10. Know which hospital rules and policies apply to the patient's conduct while a patient.

A patient's responsibilities shall include but are not limited to:
(A patient shall have the responsibility to/for:)

1. Following the recommended treatment plan.
2. Her/his actions if the patient refuses treatment or fails to follow the practitioner's instructions.
3. Following hospital rules and regulations affecting patient care and conduct.
4. Considering the rights of other patients and hospital personnel. The patient is responsible for being respectful of the property of other persons and the hospital.

Received by _____ Date / Time _____

Witness _____ Date / Time _____

Affix Patient Label

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

7085-1016
(Rev 07/15)

JUSTICE INVOLVED PATIENT'S
RIGHTS & RESPONSIBILITIES

Patient Rights Poster - Sample

Patient Rights

As a Patient at Tri-City Medical Center, you have the right to:

1. Considerate and respectful care, personal dignity and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences. You have the right to pastoral or spiritual services.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication which addresses any vision, speech, hearing, language or cognitive impairment, including the provision of interpretation and translation services free of charge, and to participate in development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. You may include family and others in your decision making process. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms. You have the right to request access to a place and phones to conduct private phone conversations.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

    The health facility must inform you (or your support person, when appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.
19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
21. Exercise these rights without regard to sex, economic status, medical condition, educational background, race, color, religion, ancestry, national origin, disability, sexual orientation or marital status or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling Tri-City Medical Center, Attention Administration, 4002 Vista Way, Oceanside, CA 92056 (760) 940-7466.

    The grievance committee will review each grievance and provide you with a written response within 10 days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO). If you are a Medicare patient, and have concerns regarding quality of care or premature discharge, you may call or e-mail the Quality Improvement Organization (QIO) at Health Services Advisory Group 1-800-880-8749. TDD Hearing Impaired: 1-800-881-5980, or www.hsag.com. You can exercise this right without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services.
23. File a complaint with the state Department of Health Services regardless of whether you use the hospital's grievance process. The state Department of Health Service's phone number and address is: 7575 Metropolitan Drive, Suite # 104, San Diego, CA 92108 (619) 278-3700.
24. File a complaint with The Joint Commission regardless of whether you use the hospital's grievance process. The Joint Commission's phone number is 1-800-994-6610 or by email complaint@jointcommission.org.

Patient Responsibilities

As a patient of Tri-City Medical Center, you have the responsibility to:

1. Provide accurate information. Patient/patient's representative must provide to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications and matters relating to their health. Patient/patient's representatives must report perceived risks in their care and unexpected changes in their condition.
2. Ask questions. Patient/patient's representative must ask questions when they do not understand their care, treatment, and service or what they are expected to do.
3. Follow instructions. Patient/patient's representative must follow the care, treatment and service developed. They should express their concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The hospital makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to plan are not recommended, patients and their families are informed of the consequences of the plan alternatives and not following the proposed course.
4. Accept consequences. Patient/patient's representative is responsible for the outcomes if they do not follow the care, treatment or service.
5. Follow the rules and regulations. Patient/patient's representative must follow the hospital rules and regulations.
6. Show respect and consideration. Patient/patient's representative must be considerate of the hospital's staff and property as well as other patients and their property.
7. Meet your financial commitments. Patient/patient's representative should promptly meet any financial obligation agreed to with the hospital.

8583-3002 (2/17)

Tri-City Medical Center

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT:** Program Flexibility

REVISION DATE(S):

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**05/17**
Nurse Executive Committee Approval:	**05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) will maintain continuous compliance with the supplemental service requirements
   a. If TCHD is unable to maintain continuous compliance with all required standards, TCHD will request an exception from the California Department of Public Health (CDPH) pursuant to Title 22 section 70307.
   b. Such approval shall provide for the terms and conditions under which the exception is granted.
   c. A written request plus supporting evidence shall be submitted by the applicant or licensee to CDPH.
   d. Any approval granted by CDPH shall be posted within TCHD.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 05/91	**SUBJECT:** Referral to Social Services for Bio~~P~~psychosocial Assessment
REVISION DATE: 04/09, 01/12	**POLICY NUMBER:** III.D.2

Department Approval:	04/17
Clinical Policies & Procedures Committee Approval:	~~09/11~~05/17
Nursing Executive Council Approval:	~~10/11~~05/17
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/11~~06/17
Professional Affairs Committee Approval:	~~01/12~~07/17
Board of Directors Approval:	01/12

A. **POLICY:**

1. Tri-City **Healthcare District (TCHD)**~~Medical Center~~ will employ only social workers that have a degree in social work from an accredited school or program. Upon referral from physicians, nurses, staff, family members, community agencies or self-~~-~~referral by the patient or through high-risk screening criteria, a qualified social worker**/social work case manager** will conduct an assessment to determine the ~~psychosocial~~**biopsychosocial** needs of the patient/family and develop a plan of action. The social worker**/social work case manager** will collaborate with and share information with the physician, nurse, and other disciplines as appropriate to the assessed needs of the patient.
2. A ~~psychosocial~~**biopsychosocial** assessment will include, but is not limited to the following:
   - **a.** Mental status of the patient
   - **b. Coping status of the patient**
   - **c. Emotional status of the patient**
   - ~~a.~~**d.** Age-specific or culture-specific needs
   - ~~b.~~**e.** Relevant psychiatric or substance abuse history
   - **f.** Social support system/family functioning
   - **g. Home situation**
   - ~~c.~~**h.** Level of social functioning/rehabilitation potential
   - ~~d.~~**i.** Level of understanding of health status and ability to cope
   - ~~e.~~**j.** Relevant socioeconomic factors**, financial status**
   - ~~f.~~**k.** Need for discharge planning
   - ~~g.~~**l.** Need for referral **and linkage** to community resources for post hospital care
3. The ~~psychosocial~~**biopsychosocial** assessment is a dynamic process that continues through the course of the patient's hospital admission. ~~The planned~~**The biopsychosocial approach systematically considers biological, psychological and social factors and their intricate interactions in understanding health, illness and the provision of health care.** ~~The~~ **pPlanned** social work intervention will be modified according to the assessed needs of the patient, in collaboration with the other staff involved in the care of the patient.
4. The plan for addressing the ~~psychosocial~~**biopsychosocial** needs of the patient may include, but is not limited to the following:
   - a. Supportive counseling **and emotional support**
   - b. Recommendation for psychiatric evaluation
   - **c.** Crisis intervention
   - **d. Anticipatory grief**

~~c.~~**e.** Report to protective agencies/police
~~d.~~**f.** Referrals/transfer to other facilities for continuing care
~~e.~~**g.** Referral~~s~~ **and linkage** to appropriate community **based** resources for post hospital care or social services

5. The assessment and plan are communicated to other appropriate staff in writing via the Interdisciplinary Database and Interdisciplinary Progress Notes (Behavioral Health Unit, Women's & Children's Services, and Neonatal Intensive Care Unit) or via PowerChart: Admission Assessment - Patient History ~~PowerForm~~**Power Form**, Clinical Notes, discussion in Interdisciplinary Case Rounds and timely interpersonal communication by phone or in person.
6. The Clinical Social Worker/**Social Work Case Manager** will interview the patient/family within 24 hours of identification of high-risk problem areas.
7. The psychosocial assessment shall be included on the patient's chart via Cerner.
8. The Clinical Social Worker/**Social Work Case Manager** will continue to update progress notes as indicated until patient/**family** is discharged.
9. Education by Social Services~~/Case Management~~ will be documented in Cerner.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 09/08	**SUBJECT:** Therapeutic Anticoagulation Management
REVISION DATE: 12/09, 3/12, 5/12	**POLICY NUMBER:** IV.B

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**~~05/12~~03/17**
Nurse Executive Committee Approval:	**~~05/12~~03/17**
Pharmacy and Therapeutics Approval:	**05/17**
Medical Executive Committee Approval:	**~~07/12~~06/17**
Professional Affairs Committee Approval:	**~~08/12~~07/17**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. Joint Commission has identified therapeutic anticoagulation (unfractionated heparin infusion, low molecular weight heparins and warfarin) as a high risk therapy that "often leads to adverse drug events due to complex dosing [and] requisite follow-up monitoring".
2. This Therapeutic Anticoagulation Program includes comprehensive anticoagulation policies, pre-printed order sets, guidelines and general tools to assist all health care providers in providing the optimal anticoagulant therapy for Tri-City ~~Medical Center(TCMC)~~ **Hospital Disctrict (TCHD)** patients. This document describes the overall Therapeutic Anticoagulation Program developed for ~~TCMC~~ **TCHD** intended to ensure regulatory compliance and improve the care of patients.
3. Given the broad, multi-disciplinary scope of the anticoagulation NPSG, this document will also be broad in scope but will emphasize the inpatient management of therapeutic anticoagulation. The ~~TCMC~~ **TCHD** Therapeutic Anticoagulation Program addresses the activities of the following department and groups:
   a. ~~Licensed Independent Practitioner (LIP)~~**Physician / Allied Healthcare Professional (AHP)**
   b. Pharmacy
   c. Nursing
   d. Dietary
   e. Laboratory
   f. Education Department
   g. Patients
   h. Patients' Families

~~A.~~**B. OVERVIEW OF THE ~~TCMC~~ TCHD INPATIENT THERAPEUTIC ANTICOAGULATION PROGRAM**

1. Prescribing:
   a. Overview:
      i. Prescribing of therapeutic anticoagulation therapy is expected to be standardized. Accordingly, all prescribers will be expected to utilize a master TC**HD**~~MC~~ Anticoagulation Dosing Policy for adults and pediatrics. This dosing policy has been developed to assist the ~~LIP~~**Physician / AHP** in appropriate medication selection (based on patient's co-morbidities), medication dosing as well as mandated baseline and follow-up medication monitoring. See appendix 1
      ii. The prescribing of anticoagulants in specialized patient care settings where it is reasonably expected for a ~~LIP~~**Physician / AHP** to be present during the entire course of therapy (such as in or en route to the cardiac catheterization laboratory or operating rooms) does not require the use of the anticoagulation dosing policy.

iii. Short term heparin usage (e.g., 4 hours or less) during the course of hemodialysis is deemed "prophylactic" anticoagulation that is not expected to produce prolonged alterations in the coagulation studies. Accordingly, heparin usage in this manner is also considered exempt from the mandatory use of the Anticoagulation Dosing Policy.

b. Unfractionated Heparin Infusion:

i. **The ~~LIP~~Physician / AHP has the option of consulting pharmacy services to manage the heparin therapy or retaining the heparin management responsibilities. The pharmacy heparin dosing/monitoring service is guided by the Pharmacy Anticoagulation Dosing Protocol that is consistent with the elements of the NPSG and approved by the organization.**

~~i.~~**ii.** For adults, if the ~~LIP~~**Physician / AHP** elects to ~~initiate an unfractionated heparin infusion~~**retain the heparin management responsibilities**, the anticoagulation dosing policy will allow the ~~LIP~~**Physician / AHP** to select one of the **23** heparin nomograms (~~High Intensity, Low Intensity, or Ultra-Low Intensity~~ **venous thromboembolism~~VTE~~/deep vein thrombosis~~DVT~~/pulmonary embolism ~~PE~~ or Cardiac**). The selection of an appropriate nomogram will depend on the patient's indication for anticoagulation and the risk for severe bleeding complications ~~(as described in appendix 1).~~

~~ii.~~**iii.** Upon receipt of the order, the inpatient clinical pharmacist will review the order for accuracy and completeness (patient weight and indication**), and ensure that the completed nomogram is entered as an order comment prior to order verification. The nomogram will be visible to the nurse within the electronic MAR**~~), generate a copy of the appropriate nomogram, complete the nomogram in accordance with the LIP order, confirm all dosing calculations (paying particular attention to maximum doses) and send up to the patient's nurse. Dosing nomograms can also be found on the TCMC intranet. The pharmacist will sign the nomogram orders with "Anticoagulation Dosing Policy, (Name) PharmD".~~

c. Low Molecular -Weight Heparin:

i. All orders for therapeutically-dosed low molecular weight heparin must be initiated on a per dosing policy basis.

ii. Guidelines to assist the ~~LIP~~**Physician / AHP** in the safe use of low molecular weight heparins based on patient's renal function or other co-morbidities are incorporated into Anticoagulation Dosing ~~Policy policy~~**Protocol**.

d. Warfarin:

i. The ~~LIP~~**Physician / AHP** has the option of consulting pharmacy services to manage the warfarin therapy or retaining the warfarin management responsibilities. The pharmacy warfarin **dosing/**monitoring service is guided by the ~~Warfarin Pharmacy Consults Policy~~**Pharmacy Anticoagulation Dosing Protocol** that is consistent with the elements of the NPSG and approved by the organization.

ii. Pharmacy services shall monitor warfarin patients to ensure compliance with required NPSG monitoring expectations before warfarin daily administration and to provide recommendations to prescribers as needed.

2. Dispensing:

a. Overview:

i. Only oral unit dose products, pre-filled syringes, or pre-mixed infusion bags will be dispensed whenever possible. If these products are not commercially available, patient-specific doses will compounded to be dispensed.

b. Unfractionated -Heparin Infusion:

i. Only standardized, pre-mixed heparin infusion bags (25,000 units/500 mL D5W) will be dispensed. No alternative strengths will be admixed nor dispensed from pharmacy services.

c. Low Molecular Weight Heparin:

i. For adults, pre-filled enoxaparin syringes (doses rounded to nearest 10 mg) will be dispensed whenever possible. If an appropriate enoxaparin does is not commercially available as a pre-filled syringe, pharmacy will compound the doses for the patient, so to eliminate the need for nursing to administer a partial syringe.

ii. For pediatrics, enoxaparin doses will be rounded to the nearest 5 mg. Pre-filled enoxaparin syringes will be dispensed whenever possible. If an appropriate ~~does~~ **dose** is not commercially available as a pre-filled syringe, pharmacy will compound the syringe, using a ~~30 mg/ 1mL~~**100 mg/mL** diluted vial.

~~i.~~**iii.** Exact warfarin doses will be dispensed for patient administration. The nursing staff will not be expected to split any warfarin tablets to obtain the prescribed dose.

3. Baseline Monitoring:
   a. Overview:
      i. Baseline laboratory monitoring within 24 hours prior to initiation of therapeutic anticoagulation will be mandated by the use of the Anticoagulation Dosing ~~Policy~~**Protocol**. The specific baseline laboratory tests that will be assessed are listed below.
   b. Unfractionated Heparin Infusion:
      i. Complete Blood Count (CBC)
      ii. Activated Partial Thromboplastin Time (PTT)
   c. Low Molecular Weight Heparin
      i. Blood Urea Nitrogen (BUN) and serum creatinine
      ii. Baseline Activated, Prothrombin Time (PT) and International Normalized Ratio (INR) are optional but recommended
4. Administration:
   a. Unfractionated Heparin Infusions
      i. All heparin infusions will be administered by a programmable infusion pump with "smart pump" technology.
      ii. All heparin bolus doses will be administered in units using the ~~5000~~ **1,000** unit per mL vial.
      iii. All heparin infusions will be programmed as units/kg/hour.
      iv. Independent double checking and documentation is to be performed as per Patient Care Services (PCS) Medication Administration Policy, IV.I.
   b. Low Molecular Weight Heparin:
      i. The air bubble is NOT to be ejected from the syringe prior to injection.
      ii. The needle shield is to be removed by pulling it straight off the syringe. For subcutaneous (SC) injections, the patient should be lying down and the injection should be administered by deep SC injection. Remove the syringe from the injection site, keeping a finger depressing the plunger rod. Activate the safety system by firmly pushing the plunger rod. A protective sleeve will automatically cover the needle. Dispose of needle in appropriate sharps container.
      iii. Rotate SC injection sites. Do not rub the injection site after completion of the injection.
      iv. Document administration of enoxaparin dose per hospital policy.
   c. Warfarin:
      i. Nursing staff will document administration of warfarin doses on the patient's medication administration record (MAR).
      ii. Pharmacy will track all warfarin dosing and monitoring via the Warfarin monitoring sheet.
5. Follow-up Monitoring:
   a. Overview
      i. Patients receiving therapeutic anticoagulation are expected to receive follow-up safety and efficacy monitoring.
      ii. All patients receiving therapeutic anticoagulation are expected to be monitored for any evidence of major oozing, bleeding or internal bleeding, changes in neurologic

status, as well as indications of an allergic reaction. The nursing staff is to notify the prescriber if any of these adverse effects are noted.

iii. According to the Critical Result and Critical Tests/Diagnostic Procedures policy all critical laboratory values are to be reported to the prescriber within 60 minutes of notification from the laboratory except in cases whereby physician/~~LIP~~**Physician / AHP** orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require physician/~~LIP~~**Physician / AHP** orders/policies for treatment of the critical results were previously available. Relevant critical laboratory results that will require physician/~~LIP~~**Physician / AHP** notification include: INR greater than 5, hemoglobin less than 7gm/dL, platelet count less than 50 K/miroliter, and PTT>200 seconds.

iv. Medication specific monitoring parameters are listed below.

b. Unfractionated Heparin Infusion:

i. PTT 6 hours after each heparin dose change and every 6 hours while stable unless otherwise dictated per policies.

ii. Nursing staff to report any fall in platelet count to less than 100K/microliter to the ~~LIP~~**Physician / AHP**.

iii. CBC every 1-3 days (default is daily).

c. Low Molecular Weight Heparin:

i. CBC every 1-3 days (default is daily).

ii. Nursing staff to report any fall in platelet count to less than 100K/microliter to the ~~LIP~~**Physician / AHP**.

iii. BUN and serum creatinine every 1-3 days (default is daily).

d. Warfarin:

i. CBC every 1-3 days (default is daily).

ii. For acute care patients, PT/INR every morning. This may be reduced to once weekly after 7 consecutive INR's within the therapeutic without requiring warfarin dose adjustments are obtained.

iii. Nutrition Services will identify all new inpatient warfarin patients on a daily basis and make necessary menu adjustments as needed.

6. Patient Education:

a. Overview:

i. ~~TCMC~~ **TCHD** staff will provide "patient/family education that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions".

ii. For all therapeutic anticoagulation, the patient and their family members will be educated about the name, indication, dosage, administration procedure, side effects, and monitoring of all anticoagulant therapies. The patient and family will be instructed to alert nursing staff of any bleeding or bruising during anticoagulation therapy.

iii. Additional discharge education will be provided as per ~~TCMC~~ **TCHD** policy.

~~B.~~C. INPATIENT PROGRAM MONITORING:

1. Overview:

a. Results of anticoagulation monitoring and adults will be reviewed by Pharmacy and Therapeutics annually, in order to reassess the safety and effectiveness of the Anticoagulation Dosing Policy and allow for re-assessment and modification, as needed.

2. Specific Monitoring Parameters

a. Safety:

i. Percentage of PTT values that fall into critical range (greater than 100 seconds) in patients receiving heparin infusions.

ii. Percentage of INR values that fall into critical range (greater than 5.0) in patients receiving warfarin therapy.

iii. Review of vitamin K and protamine usage as trigger tools for potential bleeding complications.

iv. Percentage of patients initiated on anticoagulation therapy with appropriate baseline laboratory measures (as described above).

b. Efficacy:
   i. Frequency of goal PTT measures (~~41 – 94~~**65-100** seconds, encompassing ~~all three~~ **both** heparin nomograms) in patients receiving heparin infusions.
   ii. Frequency of goal INR measures (2 – 3.5) in patients receiving warfarin therapy.

~~c. Prescribing and Monitoring Compliance:~~
   ~~i. Percentage of patients initiated on therapeutic anticoagulation for which the therapy was prescribing using the Therapeutic Anticoagulation pre-printed order set.~~
   ~~ii. Frequency of patients initiated on warfarin therapy that have documented review of drug-food interactions by dietary services.~~

~~d.~~**c.** Education Compliance:
   i. Percentage of staff pharmacists and staff nurses that have completed anticoagulation competency training.

Appendix 1 Anticoagulation Dosing Policy

Deep Vein Thrombosis or Pulmonary Embolism:
- ☐ Enoxaparin (LOVENOX) 1 mg/kg (_____mg) Sub-Q every 12 hours
- ☐ Enoxaparin (LOVENOX) 1 .5mg/kg (_____mg) Sub-Q daily
- ☐ Enoxaparin (LOVENOX) 1 mg/kg (_____mg) Sub-Q daily (if CrCl is less than 30 ml/min)

Unstable Angina, Non-ST Segment Elevation Myocardial Infarction (NSTEMI), Atrial Fibrillation/Atrial Flutter and/or Heart Valves
- ☐ Enoxaparin (LOVENOX) 1 mg/kg (_____mg) Sub-Q every 12 hours
- ☐ Enoxaparin (LOVENOX) 1 mg/kg (_____mg) Sub-Q daily (if CrCl is less than 30 ml/min)

ST Segment Elevation Myocardial Infarction (STEMi)
- ☐ Patients less than 75 years of age: Enoxaparin (LOVENOX) 30 mg IV bolus PLUS 1 mg/kg (_____ mg) Sub-Q every 12 hours (Do NOT exceed 100 mg for first 2 Sub-Q doses)
- ☐ Patients greater than 75 years of age: Enoxaparin (LOVENOX) 0.75 mg/kg (_____ mg) Sub-Q every 12 hours (Do NOT exceed 75 mg for first 2 Sub-Q doses)
- ☐ Enoxaparin (LOVENOX) 1 mg/kg (_____mg) Sub-Q every 12 hours

Atrial Fibrillation Ablation
- ☐ Enoxaparin (LOVENOX) _____ mg (usually 0.5-1 mg/kg) Sub-Q every 12 hours
- ☐ Enoxaparin (LOVENOX) _____ mg (usually 0.5-1 mg/kg) Sub-Q daily (if CrCl is less than 30 ml/min)

High-Intensity Anticoagulation Nomogram (Recommended for deep vein thrombosis, pulmonary embolism)
(DO NOT use in the setting of acute ischemic stroke, please use Ultra-low Intensity Nomgogram)
- Initial Bolus Dose:

- ☐ Omit initial bolus dose
- ☐ Give 80 units/kg bolus (not to exceed 10,000 units)
  - Begin infusion at 18 units/kg/hr (not to exceed 1,800 units/hr initially)
  - Goal PTT range: 60-94 seconds

Low-Intensity Anticoagulation Nomogram (Recommended for acute coronary syndromes, atrial fibrillation/flutter and heart valves (DO NOT use in the setting of acute ischemic stroke, please use Ultra-low Intensity Nomogram)
- Initial Bolus Dose

- ☐ Omit initial bolus dose
- ☐ Give 60 units/kg bolus (not to exceed 5,000 units)
  - Begin infusion at 12 units/kg/hr (not to exceed 1,000 units/hr initially)
  - Goal PTT range: 50-75 seconds

Ultra –low Intensity Nomogram (Recommended for blunt cerbrovascular injury and acute ischemic stroke requiring anticoagulation)
- No bolus doses
- Initial infusion rate:
- Begin infusion at 12 units/kg/hr (not to exceed 1,000 units/hr initially)
- Goal PTT range: 41-55 seconds

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 04/03	**SUBJECT: Vaccination Administration**
REVISION DATE: 06/03, 09/05; 08/08; 04/11, 02/14	**POLICY NUMBER: IV.I.10**

Department Approval:	**04/17**
Clinical Policies & Procedures Committee Approval:	**~~09/14~~05/17**
Nursing Executive Council Approval:	**~~10/14~~05/17**
Pharmacy and Therapeutics Approval:	**~~09/14~~05/17**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**~~11/14~~07/17**
Board of Directors Approval:	**12/14**

A. **PURPOSE:**

1. National Childhood Vaccine Injury Act [42 U.S.C. Sections 300aa-14 and 300aa-26, 42 C.F.R. Section 100.3] requires health care providers to furnish a Vaccine Information Statement (VIS) to a patient (or the patient's legal representative) before administering measles, mumps, rubella, polio, diphtheria, tetanus, hepatitis B, Varicella (chickenpox), haemophilus influenzae type B (Hib), pertussis and pneumococcal conjugate vaccinations. The patient or the patient's legal representative must be given this information to keep and in appropriate cases, the written material is supplemented with visual presentations or oral explanations.
2. Each health care provider who administers a vaccine is required to document the following information:
   - **a.** Administration date
   - **~~a.~~b.** **Injection site**
   - **~~b.~~c.** Vaccine manufacturer and lot number of the vaccine**, expiration date of vaccine**
   - **~~c.~~d.** Name, address, and title of the healthcare provider administering the vaccine
   - **~~d.~~e.** Publication date of the VIS given to the patient or legal representative and the date the materials were given.

B. **POLICY:**

1. Federal and California state laws do not require special informed consent prior to vaccination.
2. Not all vaccines are covered by the National Childhood Vaccine Injury Act, but at Tri-City **Healthcare District (TCHD)~~Medical Center~~**, appropriate VIS will be given and reviewed prior to any vaccination. The most current copies of VIS are available at http://www.cdc.gov/vaccines/ or www.immunize.org as well as on the hospital intranet on the home page under patient education.
3. If the patient has a medical record, the information is charted there. If the patient is seen and an individual chart is not constructed (i.e. flu-shot clinic) the above information is recorded in a log. Stickers or a stamp can be used to prompt the health care provider to record required information (see example below).

Vaccine	Date of Admin.	Manufacturer	Lot #	VIS Edition Date	Date VIS Given
Name/Title of Health Care Provider Administering					

4. Any adverse occurrence from administration of a vaccination must be reported. Refer to Patient Care Services: **Vaccine,** Reporting Adverse ~~Vaccine~~ Events Policy **and~~,~~** Administrative Policy: #236~~,~~ ~~"~~Mandatory Reporting **Requirements**.~~"~~

C. **RELATED DOCUMENT(S):**

1. **Patient Care Services: Vaccine, Reporting Adverse Events Policy**
2. **Administrative Policy: 236 Mandatory Reporting Requirements**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 04/03 **SUBJECT:** Vaccine, Reporting Adverse Events

REVISION DATE: 11/05; 06/08; 05/11 **POLICY NUMBER:** IV.I.11

Department Approval:	**03/17**
Clinical Policies and Procedures Approval:	**~~09/14~~03/17**
Nurse Executive Committee Approval:	**~~10/14~~03/17**
Pharmacy and Therapeutics Approval:	**~~09/14~~05/17**
Medical Executive Committee Approval:	**~~10/14~~ n/a**
Professional Affairs Committee Approval:	**~~11/14~~07/17**
Board of Directors Approval:	**12/14**

A. **PURPOSE:**

1. The National Childhood Vaccine Injury Act requires health-care providers to report selected events occurring after vaccination to the Vaccine Adverse Event Reporting System (VAERS).
   a. Persons other than health-care providers also can report adverse events to VAERS.

B. **POLICY:**

1. All adverse events that occur after administration of vaccines, including events that are serious or unusual, shall be reported to VAERS.
2. Any adverse occurrence from administration of a vaccination must be reported. Refer to Administrative: ~~Policy~~ #236, ~~"~~Mandatory Reporting **Policy**.~~"~~
3. VAERS forms and instructions are available in the FDA Drug Bulletin, by calling the 24-hour VAERS Hotline at 800-822-7967, or from the VAERS website at http://www.vaers.hhs.gov/ ~~(accessed June 10, 2008).~~

C. **REFERENCES:**

1. **Department of Human and Health Services. "VAERS." *Vaccine Adverse Event Reporting System*. Web. Accessed 01 Mar. 2017. <https://vaers.hhs.gov/index>.**
2. National Vaccine Injury Compensation Program, Health Resources and Services Administration, Parklawn Building, Room 8-46, 5600 Fishers Lane, Rockville, MD 20857
   Telephone: 800-338-2382 (24-hour recording)

D. **RELATED DOCUMENT(S):**

1. **Administrative: Mandatory Reporting Requirements 236**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**VASC BAND HEMOSTAT: RADIAL ARTERY COMPRESSION DEVICE**
Purpose:	To ensure continuity and patient safety using the Vasc Banc Hemostat band following radial artery catheterization by defining device application and removal, nursing assessment requirement, device complications, and nursing interventions to resolve or minimize complications.
Supportive Data:	Vasc Band Hemostat (Models 3524, 3527, 3529, 3537) Package insert – Instructions for Use, Vascular Solutions, Inc Vascular Solutions Vasc Band Hemostat Tips for Optimal Performance Vascular Solutions Vasc Band Hemostat Clinical Deployment Steps
Equipment:	Vasc Band Hemostat: Radial Artery Compression Device Syringe – 22 mL supplied with the Vasc Band Pulse Oximeter with Probe 2 x 2 Gauze Dressing Small Tegaderm or Manufacturer's Adhesive Bandage Wrist Positioning Splint

A. **DEFINITIONS:**

1. Vasc Band Hemostat: A radial artery compression device used to control surface bleeding from arterial access sites after radial artery catheter removal. For the purpose of this document, the Vasc-Band Hemostat will be referred to as a radial compression device.
2. Vasc Band: a clear plastic inflatable balloon.
3. Arterial Occlusion – A blockage of blood flow through an artery
4. Non-Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that does not block (prevent) the flow of blood through an artery.
5. Occlusive Pressure Applied to an Artery – manual pressure or pressure applied with the use of a mechanical device that blocks the flow of blood through an artery

B. **POLICY**

1. The radial artery sheath may be removed by the procedural staff or Interventional Cardiologist prior to applying the radial arterial compression device
2. The RN on the receiving unit is responsible for monitoring, weaning, and removing the radial arterial compression device post procedure.
3. The Vasc Band Hemostat may not be used to apply occlusive pressure to the radial artery at any time.
4. Do not place a blood pressure (BP) cuff or obtain blood pressure measurements on the affected arm.

C. **PROCEDURE:**

1. Application of the Radial Arterial Compression Device
   a. Using sterile technique, open the pouch and transfer the Vasc Band and syringe onto the sterile field.
   b. At the end of the catheterization procedure, withdraw the introducer sheath 2-3 centimeter (cm) from the puncture site.
   c. Align the center of the Vasc Band balloon 2-5 millimeter (mm) proximal to the puncture site and wrap the Vasc Band around the patient's extremity. Secure the device to the patients extremity using the hook and loop fastener. For optimal fit, secure the band around the extremity, allowing no room for slack, but do not overtighten.
   d. Draw 18 millimeter (mL) of air into the syringe and connect the syringe to the inflation valve on the Vasc Band

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Division of Cardiology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
NEW 01/17	**02/17**	**02/17**	04/17	n/a	06/17	07/17	

e. Slowly inject air into the Vasc Band balloon while simultaneously removing the sheath from the vessel. Once the sheath is completely removed, continue to inject air into the balloon until hemostasis is achieved. Note: the nominal air injection volume for the Vasc Band is 15 mL and the maximum air injection volume is 18 mL

f. Slowly withdraw air from the Vasc Band balloon until there is oozing from the puncture site. Once oozing is observed, re-inject 2 mL of air into the Vasc Band until complete hemostasis is achieved.

2. Post-Application of the Vasc-Band Nursing Care Areas

a. Initial Assessment on Arrival to Nursing Care Areas

i. Upon arrival to the nursing care area, assesses the following with the procedure Registered Nurse (RN) and every 5 minutes times (x) 3: (Timing begins with the first assessment performed with the procedure RN).

1) Blood pressure (BP)
2) Cardiac rhythm
3) Oxygen Saturation (SpO_2)
4) Radial pulse by palpation proximally and distal to the Vasc Band
5) Perfusion (by means of pulse oximetry, color, sensation and temperature of the arm with the Vasc Band)
6) Presence of bleeding
7) Assess temperature once on arrival and then as outlined in this policy

ii. Implement continuous pulse oximetry monitoring

1) Place the pulse oximeter probe on the index finger or thumb on affected wrist distal to the Vasc Band during compression and weaning the device.
2) Check pulse oximetry waveform
   a) If pulse oximetry waveform is not visible e.g., lost, decrease pressure slowly by removing 1 mL of air from the Vasc Band until a waveform is visible
   b) If pulse oximetry waveform is lost and bleeding is present see management of bleeding

iii. Document the vital sign results and assessment findings in the Electronic Health Record (EHR)

b. Vital Signs

i. Assess the following every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the Vasc Band is removed and then per unit policy

ii. Vital signs assessment includes the following:

1) BP
2) Heat rate
3) Cardiac rhythm
4) Respiratory rate
5) Oxygen saturation
6) Temperature as ordered

iii. Document the vital sign results in the Electronic Health Record (EHR)

c. Procedure Site Assessment

i. Procedure site assessments shall be performed every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the Vasc Band is removed, then per the Standards of Care or unit policy.

ii. Procedure site assessment includes but is not limited to the following:

1) Assess the procedure site for the presence of bleeding e.g., ., new or an increase presence of blood, blood oozing around balloon and/or the presence of a hematoma as follows or as ordered
2) Assess perfusion of procedure hand (by means of color, sensation and temperature of the arm with the Vasc Band)
3) Palpate the radial pulse

iii. Document the assessment findings in the Electronic Health Record (EHR)

3. Neurovascular Assessments
   a. Perform a neurovascular assessment with vital signs and site assessments
   b. The Vasc Band should be left on the patient's extremity for at least 2 hours following catheterization unless directed otherwise by physician's order or patient's condition.
      i. Perform a neurovascular assessment with vital signs and procedure site assessments
4. Device Removal
   a. Maintain the Vasc Band in for the recommended device removal time, withdraw 2 mL of air from the Vasc Band and observe the puncture site for bleeding
   b. If bleeding is present, re-inject 1-2 mL or air to restore hemostasis. Wait 30 minutes and repeat Device Removal process
   c. If no bleeding is present, continue to remove 2 mL of air every 15 minutes x 3 or until pressure is fully released e.g. the Vasc Band balloon is depressed.
   d. When the pressure is fully released and hemostasis is confirmed, carefully remove the Vasc Band from the puncture site, being careful not to disrupt the clot.
   e. Apply a 2 x 2 gauze dressing and secure the dressing with a tegaderm dressing.
5. Management of Bleeding
   a. Ensure device is in the proper position
   b. Slowly inject enough air in the Vasc Band balloon to restore hemostasis. Do not inject more than 15 mL of air.
   c. Palpate for the presence of a radial pulse. A palpable radial pulse must be present at all times.
   d. Do not over-inflate the compression device to occlude radial pulse
   e. Notify the physician immediately if unable to regain hemostasis.
   f. Uncontrolled bleeding:
      i. Remove radial arterial compression device, elevate arm while applying manual pressure to the radial artery proximal to the puncture site to stop the bleeding.
      ii. Notify Physician immediately.
6. Removing the Dressing
   a. Remove dressing within 24 hours of application or prior to discharge for inpatients. Do not disrupt the clot.
   b. Apply a Band-Aid to puncture site or leave open to air if ordered
7. Reportable Conditions
   a. Notify the procedure Physician immediately if any of the following occur:
      i. New onset of distal pain, numbness, tingling, duskiness, bleeding, unable to palpate the radial pulse, or circulation to the hand appears compromised
8. Documentation
   a. Document the following in the Electronic Health Record (EHR)
      i. All assessments
      ii. Vital signs with pulse oximetry results
      iii. Neurovascular assessments
      iv. Dressing applications and changes
      v. Physician Notification
      vi. Education provided – use Depart Custom Education leaflet Radial Artery Cardiac Catheterization/Angioplasty Discharge Instructions

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**WASTING NARCOTICS, DOCUMENTATION IN THE PYXIS MACHINE**
Purpose:	**To outline the process and corresponding documentation for wasting controlled substances in the Pyxis.** ~~To outline nursing responsibilities in wasting narcotic medication.~~

~~A. **PURPOSE:**~~

~~1. To outline the process and corresponding documentation for wasting controlled substances in the Pyxis.~~

~~B.~~**A. DEFINITIONS:**

1. Pyxis: Automated Dispensing Machine used to dispense and track controlled substances.
2. Approved licensed health care professional
   a. Anesthesiologist
   b. Registered Nurse
   c. Licensed Vocational Nurse
   d. Respiratory Care Practitioner
   e. Radiology Technician
   f. Pharmacist
   g. Pharmacy Technician

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

1. Wasting Single Dose Narcotics and Patient – Controlled Analgesia (PCAs):
   a. Select "Waste" key
   b. Select patient's name and a list of medications removed in the past 24 hours will appear.
   c. Select medication to be wasted
   d. Type in amount of medication given (amount to waste will be automatically filled in)
      i. When wasting PCAs, drips or epidurals the waste amount will be in milliliters
   e. Waste requires another nurse or other approved licensed health care professional to witness~~.~~
   f. Select "Accept" key
   g. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the ~~enclosed table~~**current waste disposal guidelines**.
2. The above process can also be completed in Pyxis at time of medication removal. The Pyxis will prompt the nurse to enter information in steps d and e at time of removal. Steps a-c will not need to be completed.
3. Wasting controlled substances that were not removed from same Pyxis
   a. Select "Waste" key
   b. Select patient's name. Since the medication was not originally removed from this Pyxis, the medication will not be listed on the patient's profile.
   c. Select "all meds" key and a list of all meds will appear on the screen
   d. Select medication to be wasted
   e. Type in amount of medication given (amount to waste will be automatically filled in)
   f. Waste requires another nurse (or other approved licensed health care professional) to witness.
   g. Select "Accept" key
   h. Upon completion of documentation, both people signing for waste must properly dispose of excess medication based on the ~~enclosed table~~**current waste disposal guidelines**.
4. **See Waste Disposal Guidelines for wasting**~~The following processes should be used to waste~~ controlled substances.

Department Review	Clinical Policies & Procedures	~~Patient Quality Care Committee~~Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/03, 06/09, 07/12, **09/15, 02/17**	07/12, **10/15, 03/17**	08/12, **10/15, 03/17**	**12/15, 05/17**	08/12, **02/16, 06/17**	09/12, **07/17**	09/12

~~Tablets, **Oral liquids, Injectable (syringe*/bags), Patches, and Lollipops**~~	~~Place in Sharps Container~~ **~~Dispose of in toilet Dispose in the designated RX Destroyer controlled substance container. * Empty syringes shall be placed into a Sharps Container.~~**
~~Oral liquids~~	~~Flush down drain with copious amounts of water~~
~~Injectable (syringes/bags)~~	~~Flush down drain with copious amounts of water~~
~~Patches (unused, partially used, used)~~	~~Fold patch so adhesive adheres to self and discard into Sharps Containers~~**~~toilet.~~**
~~Suppositories~~	~~Break up and place in Sharps Container~~**~~toilet.~~**
~~Lollipops~~	~~Deposit in Sharps Container~~**~~Cut off medicated end and dispose of in toilet.~~**

C. RELATED DOCUMENT(S):

~~a.~~1. **Waste Disposal Guidelines**

TCMC Waste Disposal Guidelines

						
Regular Waste NO NEEDLES	**Biohazardous Waste** NO NEEDLES	**Sharps** NEEDLES OK	**Pharmaceuticals** NEEDLES OK	**Controlled Substances** NO NEEDLES	**RCRA Pharmaceuticals** NO NEEDLES	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ **All sharps** *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with **pourable** medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** *Examples:* ▫ *Insulin/Insulin Pen (needles removed)* ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Used & Unused nicotine gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** **Return to pharmacy** all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

						
Regular Waste: Clear Bag	**Biohazardous Waste: Red Bag**	**Sharps: Sharps Containers**	**Pharmaceuticals: Containers**	**Pharmaceuticals: Black R.C.R.A.**	**Chemo/Hazardous Waste: Yellow Bin/Bag**	**Confidential: Shred-it-Bins**
▫ Empty IV bags, Piggyback bags/tubing without PHI * or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes **No PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping blo dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ All sharps *Example: needles (including insulin pen needles), lancets broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* from procedures etc.	▫ Syringes, needles, tubexes, carpujects with (pourable) medication ▫ Partially used or wasted prescription or over-the-counter medication *Examples: vials, tablets,* ▫ Patches (fold in half) ▫ Inhalers with no propellants *Examples: Advair, Foradil* ***Controlled substance tabs, caps and patches are disposed of in toilet. Fold patch in on itself or place on toilet paper before discarding.* **No PHI**	**Hazardous R.C.R.A. Pharmaceuticals:** *Examples:* ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Insulin/Insulin Pen* *otine* *clude empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **No PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** **Return to pharmacy** all unused bulk chemo in original pharmacy bag for credit or disposal **No PHI**	**ALL MATERIALS CONTAINING PHI*** Must be disposed of in locked "Shred-It" Containers Examples: Handwritten or computer generated ▫ paper ▫ wristbands ▫ labels, etc ***PHI: Patient Health Information**

DELETE – see revised grid

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330) All other bins supplied by EVS (760-644-6973)
If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973 Revised Date: 06/2015 pharmacy

References:
http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf
County of San Diego Department of Environmental Health Hazardous Materials Division
Stericyle
Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

ISSUE DATE: 03/94

SUBJECT: ASSAULT AND BATTERY REPORTING PROCESS

REVISION DATE: 06/95, 10/99, 05/03, 02/09, 06/11, 04/14

POLICY NUMBER: 8610-241

Department Review:	05/17
Administrative Policies & Procedures Committee Approval:	~~04/14~~06/17
Professional Affairs Committee Approval:	~~06/14~~07/17
Board of Directors Approval:	06/14

A. **PURPOSE:**

1. To establish a uniform system for the reporting of all assault**ive behavior** (Section 240, California Penal Code) and battery (Section 242, California Penal Code) occurrences against on-duty **Tri-City Healthcare District (TCHD)** ~~Medical Center~~ personnel, **or other covered individuals under Cal/OSHA Workplace Violence Prevention regulations,** which results in **threats of** injury, **physical injuries** or involves the use of a firearm or other deadly weapon. ~~(Also r~~**R**efer to Administrative Policy: **Mandatory Reporting Requirements** 236.~~)~~

B. **DEFINITION(S):**

1. Assault**ed Employee**: **Any employee (or covered individual) of TCHD who is reasonably put in fear of being imminently struck by a patient,** ~~or~~ **visitor, co-worker, physician or other individual either by a menacing gesture, sudden move alone, or accompanied by a threat**~~An assault is an unlawful attempt, coupled with a present ability, to commit a violent injury on the person of another.~~ (California Penal Code Section 240, **Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)).**
2. Batter**ed**~~y~~ **Employee**: **Any employee (or covered individual) of TCHD who experiences actual uninvited physical contact from a patient,** ~~or~~ **visitor, co-worker, physician or other individual whether or not a physical injury occurs**~~A battery is any willful and unlawful use of force or violence upon the person of another~~. (California Penal Code Section 242, **Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)).**

C. **POLICY:**

1. It is the policy of the ~~Medical Center~~ **TCHD** Security Department that all occurrences involving an assault or battery against any ~~Medical Center~~ **TCHD** employee **(or covered individuals)** be properly documented and all pertinent information forwarded to the **local** law enforcement agency of jurisdiction within ~~72~~ **48** hours of the time of the incident.
2. Pursuant to ~~Medical Center~~ **TCHD** Administrative: **Security Department Incident Notification** Policy #234, when either an assault**ive behavior** or battery is committed against any on-duty **TCHD** employee **(or covered individuals)** ~~of the Medical Center~~, the Security Department will be notified **immediately** of the incident by the employee or immediate supervisor and respond with necessary personnel.
3. The primary responding security officer will be responsible to ensure that all processes described **per** ~~in~~ **the** ~~TCHD~~**Security: Safety and Security Incident Investigation 233 Policy** ~~Security Department Policy #090 (Safety/Security Incident Investigation)~~, are immediately implemented and properly documented ~~per the departmental policy~~. In addition, **the responding security officer** ~~he/she~~ will be responsible for the following **items:**
   ~~3.~~**a. Insure** ~~that TCHD personnel~~**the individual has been offered medical services and document the extent of injuries if present.**

~~a.~~**b.** Immediately notify the **on-duty** Security Supervisor/designee of all available facts relating to the incident.

c. If needed, **the responding security officer will request** the immediate notification and request for assistance of the Oceanside Police Department **(OPD)**.

~~b.~~**d.** **The responding security officer will be responsible for the**~~The~~ completion and submission of all required **TCHD** Security Department Reports (as per ~~departmental~~ **Security: Security Department Reports #111** Policy) pertaining to the occurrence ~~at~~ **by** the end of the primary responding officer's **designated** shift. **The reports shall include, evidentiary photos, witness statements, perpetrators disposition, and any damage to TCHD property during the altercation.**

4. The Security Supervisor/designee will be responsible to ensure the following is completed on the next working day after the occurrence:

a. Review of all submitted departmental reports **and evidentiary material by the responding security officer that**, pertain~~ing~~ to the occurrence.

b. Conduct **and document** any additional follow-up investigation.

~~b.~~**c.** **Ensure Employee Health (EH) is notified by dialing "7050" and either speaks directly with the EH staff or leave a message with the basic details (example: Employee name, date, time and location of incident, extent of the injuries if known). EH will complete the necessary reporting to Cal/OSHA.**

~~c.~~**d.** Ensure that **TCHD** Administration ~~personnel~~ and the Risk Manager are ~~completely~~ briefed regarding all available facts pertaining to the occurrence.

~~d.~~**e.** Ensure that written notification of the occurrence is forwarded to the law enforcement agency of jurisdiction within ~~72~~**48** hours of the time of occurrence. In addition, a copy of the~~is~~ notification will **also** be attached to the ~~primary~~ responding **security** officer's report and forwarded to the Medical Center Risk Manager for review and recommendations.

D. **RELATED DOCUMENT(S):**

1. **Administrative Policy: Mandatory Reporting Requirements 236 Policy**
~~a.~~**2.** **Administrative Policy: Security Department Incident Notification 234 Policy**
3. **Security: Safety and Security Incident Investigation 233 Policy**
4. **Security: Security Department Reports 111 Policy**

E. **REFERENCES:**

1. **California Penal Code Section 240 & 242**
~~1.~~**2.** **Cal/OSHA Title 8, California Code of Regulations, Sec. 3203 (b); 5120€(1)(B); 3342(h)(3)**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Patient Care

ISSUE DATE:	**04/93**	**SUBJECT:**	**Assault Victims/Domestic Violence, Reporting Requirements**
REVISION DATE:	**05/93; 08/94; 04/95; 07/99; 04/02, 06/03; 12/05; 04/09; 06/11**	**POLICY NUMBER:**	**8610-310**

Department Approval:	**04/17**
Clinical Policies and Procedures Approval:	**05/17**
~~**Administrative Policies & Procedures Approval:**~~	~~**05/11**~~
Nurse Executive Committee Approval:	~~**06/11**~~**05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	~~**06/11**~~**07/17**
Board of Directors Approval:	**06/11**

A. **PURPOSE:**

1. To provide guidelines for compliance with the mandatory reporting requirements for any patient injuries incurred through assault with a deadly weapon, a criminal act or instances of domestic violence presenting at Tri-City Hospital District (TCHD).
   (For assault and battery occurrences against on-duty Medical Center personnel refer to Administrative: **Assault and Battery Reporting Process** Policy #241, and for Uniform Reporting, **and** Reporting Requirement Grid, **refer to** Administrative: **Mandatory Reporting Requirements** Policy #236).

B. **DEFINITIONS:**

1. Victim – A person who has been subjected to injury through assault, a criminal act, or incident of domestic violence.
2. Injury – Any physical injury, which requires any form of professional medical treatment.
   a. Does not include any psychological or physical condition brought about solely through voluntarily administration of a narcotic or restrictive dangerous drug.
3. Abuse – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment.
   c. Sexual Abuse – Includes sexual harassment, coercion and assault.
   d. In out-of home care - situations where child abuse is suspected and the person responsible for the child's welfare is a licensee, administrator, or employee of a child care facility, private or public residential home, school, or other institution.
4. Imminent Danger – Foreseen danger that will likely result in irreparable physical or mental harm unless conditions are changed.
5. Exploitation – An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
6. Domestic Violence – The occurrence of any of the following: battery; simple battery; simple assault; assault; stalking; criminal damage to property; unlawful restraint; or criminal trespass by a present or past spouse, parents of the same child, parents and children, stepparents and stepchildren, foster children and foster parents or others living or formerly living in the same

household.

7. Health Practitioner - Physician, psychiatrist, psychologist, social worker, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, ~~an~~ emergency medical technician, or any person who is licensed under Business and Professions Code Section 500.
8. Reporting - Refers to mandated verbal and written report to law enforcement agencies pursuant to California Penal Code 11160 et seq. Failure to report an injury caused by an assault with a deadly weapon or an incident of domestic violence is a criminal offense.

C. **POLICY:**

1. California Penal Code Sections 11160 and 11161 require health practitioners and physicians, to immediately report, both by phone and in writing: (A single report may be made when the obligation to report falls to two or more persons)
   a. All injuries resulting from the use of a gun, knife, firearm, or other deadly weapon, whether inflicted by ones own act or by the actions of another, and
   b. Any wounds or physical injuries inflicted upon a person where the injury is the result of assaultive or abusive conduct. (Penal Code Section 11160)
   c. The following criteria may indicate a need for further assessment~~.~~ **(including but not limited to):**
      i. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches).
      ii. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
      iii. Poor hygiene, malnourishment.
      iv. Fear of parent or caregiver, being withdrawn or tearful.
      v. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
      vi. Inappropriate responses to questions about a safe environment or being threatened at home.
   d. Duty to report is required when the health practitioner provides medical services to a patient for any physical condition, not just the condition or injury from an assault, battery, or firearm incident.
   e. The report shall be prepared even if the patient has expired or declines to report.
2. Pursuant to Penal Code Section 11161.9, a health practitioner who makes a report of injury or abuse as specified under the law shall not incur any civil or criminal liability as a result of making such report.
3. Any evidence procedure or with a victims injured by a deadly weapon or criminal act must be properly handed, retrieved and proper chain of custody maintained. (See Administrative Policy # 315)
4. Physician-patient privilege does not relieve any physician from his/her obligation to report acts of domestic violence to law enforcement pursuant to Penal Code Sections 11161 (a).
5. Other Health Practitioners are not relieved of their reporting obligation if a physician or surgeon fails to report an injury by deadly weapon or criminal act. Any health practitioner may make the report. No supervisor or administrator shall impede or inhibit the reporting duties required pursuant to Penal Code 11160.
6. For the purposes of this section, "assaultive or abusive conduct" shall include any of the following offenses:
   a. Murder, (violation of Section 187).
   b. Manslaughter, (violation of section 192 or 192.5).
   c. Mayhem, (violation of Section 203).
   d. Aggravated mayhem, (violation of Section 205).
   e. Torture, (violation of Section 206).
   f. Assault with intent to commit mayhem, rape, sodomy, or oral copulation, (violation of Section 220).
   g. Administering controlled substances or anesthetic to aid in commission of a felony, (violation of Section 222).
   h. Battery, (violation of Section 242).

i. Sexual battery, (violation of Section 243.4).
j. Incest, (violation of Section 285).
k. Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, (violation of Section 244).
l. Assault with a stun gun or taser, (violation of Section 244.5).
m. Assault with a deadly weapon, firearm, assault weapon, or machine gun, or by means likely to produce great bodily injury, (violation of Section 245).
n. Rape, (violation of Section 261).
o. Spousal rape, (violation of Section 262).
p. Procuring any female to have sex with another man, (violation of Section 266, 266a, 266b, or 266c).
q. Child abuse or endangerment, (violation of Section 273a or 273d).
r. Abuse of spouse or cohabitant, (violation of Section 273.5).
s. Sodomy, (violation of Section 286).
t. Lewd and lascivious acts with a child, (violation of Section 288).
u. Oral copulation, (violation of Section 288a).
v. Genital or anal penetration by a foreign object, (violation of Section 289 or 289.5).
w. Elder abuse, (violation of Section 368).

7. All assault or domestic violence cases must be reported within mandated time lines by phone and written report to the appropriate law enforcement agency where the alleged incident occurred.
8. Victim of Assault: Upon learning or reasonably suspecting that a patient may be a victim of assault, the Health Practitioner will use the following procedure.
   a. Make a report by phone immediately or as soon as practically possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.
   b. Complete a written report on the form "Health Practitioner and Hospital Report of Injuries by Deadly Weapon or Criminal Act". Distribute as follows:
      i. Keep one copy for patient's chart.
      ii. Mail one copy to appropriate law enforcement agency where alleged assault occurred.
      iii. Mail written report within 2 working days to appropriate law enforcement agency.
   c. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.
9. **If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:**
   a. The health care provider believes, in the exercise of professional judgement, that ~~the~~ informing the patient would place him or her at risk of serious harm~~, or~~
   b. The health care provider would be informing a personal representative~~.~~, and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient
   ~~d.~~c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.

~~9.~~10. In the Emergency Department the social worker may be requested to provide a psychosocial assessment or consultative services to the Emergency Department or attending physician. They may also provide crisis intervention, problem solving advocacy, information and referral to community resources.

~~10.~~11. In the acute care setting, social work services are available to provide assessment, crisis intervention problem solving, advocacy, and information and referral to community resources.

~~11.~~12. According to Government Code Sections 13959 through 13969.1, California residents may apply for restitution for pecuniary losses they suffer as a direct result of criminal acts.
   a. The Emergency Department will display information regarding the "Victims of Crime

Program". (Refer to CHA Consent Manual)

b. A referral may be made to Social Services, to provide information and an application to the patient, for assistance through the "Victims of Crime Program".

c. The nurse can provide the patient with the following information and the patient and/or family can follow-up: ~~with them.~~

i. State Board of Control
~~ii.~~ P.O. Box 3036
~~iii.~~ Sacramento, CA 95812-3036
~~iv.~~ (916) 322-4426

~~12.~~**13.** Victim of Domestic Violence: Upon learning that a patient may be a victim of domestic violence,~~;~~ the Health Practitioner will use the following procedure:~~.~~

a. Make a report by phone immediately or as soon as possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.

b. Request the presence of a police officer at the hospital to interview the victim and conduct an investigation. Every effort should be made to keep the victim at the hospital until an officer arrives.

c. The Health Practitioner will complete a written report on the form "Domestic Violence and Violent Injury Report" and will forward the written report immediately to ~~Tri-City Medical Center~~**TCHD**'s Social Services Department. One copy will be mailed to the appropriate law enforcement agency (within 2 working days). One copy will be filed in Social Services to protect patient safety and confidentiality.

d. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.

~~13.~~**14.** All suspected, or confirmed, domestic violence cases identified on any inpatient unit, are to be referred to ~~Tri-City Medical Center~~**TCHD**'s Social Services Department. A clinical social worker may assess the patient/family system and will coordinate with the attending physician and nursing staff to ensure the required telephone and written reports are completed within the required time frames.

~~14.~~**15.** The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of assault/violence to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.

~~15.~~**16.** Social Services Department will be notified of all cases of suspected assault/violence by one of the following methods:

a. Making a Social Services referral through the computer.

b. By telephone to the Social Services Department or page to a specific Social Worker.

c. By completing a "Health Practitioner Report of Injuries by Deadly Weapon or Assaultive/Abusive Conduct" Reporting Form and forwarding it to the hospital Social Services Office.

~~16.~~**17.** Any problematic cases are reported to the Director/Manager of Social Services and the Director of Risk Management for additional review.

~~17.~~**18.** As high-risk patients, all alleged or confirmed victims of child abuse, elder abuse and domestic violence cases presenting in the Emergency Department should involve an assessment by the Emergency Department social worker.

~~18.~~**19.** In instances where victims include children, seniors or dependent adults, or domestic violence situations, the respective county social service hot lines (for child or elder abuse) are called, and mandated written reports are completed and mailed. Refer to Administrative**: Reporting Suspected Child Abuse** Policy~~ies~~ #308 ~~– Child Abuse~~ and **Administrative: Reporting Suspected Dependent Adult Elder Abuse Neglect** #309~~– Elder Abuse~~.

D. RELATED DOCUMENT(S):

1. **Administrative: Assault and Battery Reporting Process Policy #241**
2. **Administrative: Mandatory Reporting Requirements Policy #236**
3. **Administrative: Reporting Suspected Child Abuse Policy #308**

~~10.~~4. **Administrative: Reporting Suspected Dependent Adult Elder Abuse Neglect #309**

~~D.~~E. **REFERENCE(S):**

1. **California Hospital Association. (2017~~6~~). *California Hospital: Consent Manual*. CHA Publications: Sacramento.** ~~California Hospital Association Consent Manual~~;
2. California Penal Code~~;~~
~~1.~~3. www.jointcommission.org

Tri-City Health Care District
Oceanside, California

Administrative Policy

ISSUE DATE: 03/00 **SUBJECT: Consent to Photograph/Videotape**

REVISION DATE: 05/03, 01/06, 06/06, 06/09 **POLICY NUMBER:** 8610-372

Department Approval:	**05/17**
Administrative Policies and Procedures Committee Approval:	**05/17**
~~**Clinical Policies and Procedures Committee Approval:**~~	~~**08/15**~~
~~**Nurse Executive Operations Team Committee Approval:**~~	~~**05/0909/15**~~
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	~~**06/09**~~**07/17**
Board of Directors Approval:	**06/09**

A. **PURPOSE:**

1. To provide guidelines for photography/videotap**inge** within **Tri-City Healthcare District (TCHD)**~~the Medical Center~~**. Health care providers and outside parties, such as visitors, vendors, law enforcement officers, or the media may photograph patients for various purposes, including patient identification, diagnosis and treatment, patient and/or professional education, research, public relations, marketing, security, and documentation.**

B. **DEFINITION(S):**

1. Photograph**/videotape** includes video or still photography, in digital or any other format including cellular phones with camera and any other means of recording or reproducing images.

~~1.~~**2. Publication: means any method of displaying or distributing photographs, including simply showing the photograph to one or more individuals.**

~~2. Directly identifiable shall mean uniquely recognizable such as facial features.~~

C. **POLICY**

1. **Hospital staff (including medical staff) may not take photos of patients unless specifically allowed by this policy and staff may not show any photos of patients to others persons within or outside the hospital unless specifically allowed in this policy. This is true even if the patient's face is not visible or the employee thinks the patient "doesn't mind."**
2. **Hospital staff may not use their personal cell phones or other personal equipment to photograph patients, and may not post patient pictures, on social media websites.**
3. **Hospital staff must understand that approval of administration is required prior to allowing photo~~p~~graphy not addressed in this policy or for exceptions to this policy.**
4. **Photographing a patient without his or her consent or over his or her objection, may constitute an invasion of the patient's legally protected right to privacy.**
5. When recordings or films are made for **publication**/external purposes that will be heard or seen by the public, for example, commercial filming, television programs, marketing, there is documentation of a specific, separate consent that includes circumstances for the use of the recording or film.
   a. Patients will not be photographed in any manner without consent except as situations noted below in this policy. Situations not addressed by the following policy will be **reviewed by** ~~interfaced through Administration/~~Risk Management.
   b. Photography of suspected victims of child abuse **or neglect**, elder abuse **or neglect**, dependent adult abuse **or neglect**, or domestic abuse may be obtained without patient's

prior consent. ~~The attending physician's order must be obtained.~~

c. Anyone who engages in recording or filming (who is not already bound by the hospital's Confidentiality policy) will sign a confidentiality statement to protect the patient's identity and confidential information.

d. Consent for routine photography of wound care and decubitus ulcer is covered in item one of the Tri-City Healthcare District Conditions of Admission.

e. Consent for routine photography of newborns is covered in item one of the Tri-City Healthcare District Conditions of Admission.

i. Photography or video taping of labor and the birthing process shall be possible **unless it invades the privacy of other patients or interferes with operations of the hospital or its services to patients** ~~with the consent of, and at the discretion of the attending physician~~.

6. The "Consent to Photograph and Authorization for Use or Disclosure" form must be completed whenever the hospital~~, and authorized member of the medical staff (or a representative thereof),~~ or any person not requested to do so by the patient, desires to take a photograph or video of a patient or any part of the patient's body for purposes not directly related to the medical treatment of the patient.

a. This includes photographs or videos taken for patient education, medical education, or research purposes, which may be used for external purposes that will be heard or seen by the public.

7. Photograph or videotaping used for diagnosis or treatment purposes are part of the medical record and must comply with all the legal requirements of confidentiality and retention.

8. Videotapes used for ~~consultation and~~ education purposes are not part of the patient's medical record. Therefore, anyone, including the patient who requests the medical record, does not have a right to access the videotape.

9. Obtaining consent for the taking and use of a photograph(s) or videos are designed to reduce the risk that liability will be imposed on the hospital on the basis of invasion of the patients' privacy or an unauthorized use of the patient's photograph. Except for circumstances set forth below, there is documentation of consent before recording or filming,

~~a. The following occurs in situations in which the patient is unable to give informed consent before recording or filming.~~

~~b.~~**a.** The recording or filming may occur before consent, provided it is with the established policy of the hospital. ~~and the policy is established through an appropriate ethical mechanism (such as Ethics Committee) that may include community input.~~

~~c.~~**b.** The recording or film remains in the hospitals possession and is not used for any purpose until and unless consent is obtained.

~~d.~~**c.** If consent for use cannot subsequently be obtained, the recording or film is either destroyed or the non-consenting patient must be removed from the recording or film.

~~e.~~**d.** If consent for use cannot subsequently be obtained, the filming or recording cannot be used in marketing materials.

10. The patient/legal representative will sign, date and time the "Consent to Photograph and Authorization for Use or Disclosure" form.

~~a. The signature must be witnessed and the witness must sign in the space provided in the form.~~

~~b.~~**a.** The person obtaining the consent will specifically explain what, if any, particular uses of the photograph or video is anticipated and, further, to explain that by signing the form, consent is given for those particular uses as well as any further or different uses unless specific restrictions are noted.

~~c.~~**b.** If the patient states any restrictions, the hospital would not use the photograph in the unauthorized manner.

~~d.~~**c.** If a photograph will be used in a general publication and that use was not specifically contemplated at the time the photograph was taken~~,~~ **then:** ~~it is advisable not to rely upon the general consent that was previously given.~~

i. The patient/legal representative must be notified and given an opportunity to

object.

ii. A record must be maintained documenting that the patient was contacted and did not (or did) object to the proposed use. Any restrictions imposed by the patient/legal representative will be respected.

~~e. The original form will be placed in the patient's medical record and a copy given to the patient.~~

11. When a patient requests to have photographs/videos taken of herself/himself, or if parents request that pictures be taken of their hospitalized child, **the photography or videotaping shall be possible unless it invades the privacy of other patients or interferes with the operations of the hospital or its services to patients.**~~and if the request differs from the hospital's policy (e.g., it would be necessary in taking photographs to install or use equipment which would interfere with the operations of the hospital or its services to patients), the request will be referred to administration/risk manager.~~
    a. Consent given pursuant to this provision does not authorize the use of the photographs for any purpose other than those listed in this policy.
12. Nurses, auxiliary, medical staff, visitors and ~~Tri-City Healthcare District (~~TCHD~~)~~ employees shall not be included in photos/videos unless their consent is obtained.
13. TCHD reserves the right to terminate~~. F~~ **filming or recording if the process interferes with care of the patient during an emergency situation,** ~~or~~ **would aggravate the patient's condition or TCHD employees, or interferes with the patient care of hospital business.**~~filming or recording if the process interferes with care of the patient during an emergency situation or would aggravate the patients condition or TCHD employees or interfere with patient care or hospital business.~~
14. When a representative of either the news media or law enforcement agencies request to photograph a patient in the hospital, such permission may be given if:
    a. In the opinion of the attending physician, the patient's condition will not be jeopardized.
    ~~a.~~**b. The patient consents to have the photograph taken by signing a consent to photograph or videotape.**
    ~~b.~~**c.** In the process of conducting a criminal investigation, law enforcement agencies need photographs for evidence (State of California Evidence Code 1500, 1500.6).
    ~~c.~~**d.** If above criteria are not met, news media may be escorted by security off hospital property, if they interfere with operations of the hospital, its services to patients or if they are photographing people without their permission.
15. If a patient's photograph will be used for marketing **or philanthropy** purposes, written consent is required which specifically grants permission for such marketing **and/or philanthrop~~h~~y**.
16. A new consent form will be signed for each new series of photographs, and for photographs taken of persons other than those named in prior consents.
    a. The consent given for the use of photographs or videos remains valid unless and until the patient or his/her legal representative notifies the hospital that he/she is withdrawing or restricting authorization for any future use.
17. **Except with regard to security footage captured and maintained by TCHD, ~~P~~p**atients, physicians, employees, volunteers or visitors have the right to request cessation of recording or filming and the right to rescind consent for use up until a reasonable timeframe before the recording or film is used **unless the recording or filming has been produced in response to a lawful subpoena or otherwise required by law**.

~~17.~~**18. TCHD maintains security cameras located throughout the facility. The cameras and the footage captured by the cameras are part of TCHD's operations and are used to enhance the safety of its facilities. As a result, patients, visitors, staff, and others may be captured as part of the security footage maintained by TCHD. Under certain circumstances TCHD may, in accordance with this policy and relevant privacy laws, produce copies of photographs or videos captured by the security cameras to facilitate hospital security operations and/or to law enforcement or others as required by law.**

~~18.~~**19.** For further questions regarding photography of patients **including Law Enforcement officers using policy body cameras and Google Glasses,**~~,~~ please refer to the California Hospital

Association Consent Manual.

D. **FORM(S)~~/RELATEDREFERENCED FORM WHICH CAN BE LOCATED ON THE INTRANET~~:**

1. **Consent to Photograph / Video Form - Sample**
2. Consent To Photograph and Authorization for Use or Disclosure Form **- Sample**
3. **Consent to Photography for Philanthropy**

E. **RELATED DOCUMENT(S):**

1. **Administrative Police 8610-479 Social Media**
2. **Administrative Policy 8610-257 Cellular Phones and Other Wireless Electronic Digital Devices Use Of**
3. **Tri-City Healthcare District Conditions of Admission**

~~E.~~F. **REFERENCE(S):**

1. California Hospital Association Consent Manual **2017**
2. **State of California Evidence Code 1500, 1500.6**
3. **The Joint Commission** Hospital Accreditation Standards ~~JCAHO 2006~~ Manual **(2015)**

Consent to Photograph and Authorization for Use or Disclosure Form

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Patient Name: _____

CONSENT TO PHOTOGRAPH AUTHORIZATION FOR USE AND DISCLOSURE

I hereby consent to be photographed while receiving treatment at Tri-City Medical Center. The term "photograph," includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.

I hereby authorize the use of the photograph(s) by or disclosure of the photograph(s) to:

_____

_____

(Persons/Organizations authorized to receive the in information) (Address – street, city, state, zip code)

PURPOSE

I hereby authorize the use or disclosure of the photograph(s) for the following uses or purposes (describe permitted uses, e.g., dissemination to hospital staff, physicians, health professionals, and members of the public for educational, treatment, research, scientific, public relations, and charitable purposes):

_____

_____

_____

I consent to be photographed and authorize the use or disclosure of such photograph(s) in order to assist scientific, treatment, educational, public relations, and/or charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Tri-City Medical Center, its employees, my physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

EXPIRATION

This Authorization expires *[insert date]*: _____

PURPOSE

I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: Patient Information Services, Tri-City Medical Center, 4002 Vista Way, Oceanside, CA 92056-4506. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Consent and Authorization.

I may inspect or obtain a copy of the photograph whose use or disclosure I am authorizing.

Initials: _____

I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.

I have a right to receive a copy of this Authorization.

Information disclosed pursuant to this Authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

If this box ☐ is checked, Tri-City Medical Center will receive compensation for the use or disclosure of my photograph(s).

SIGNATURE

Date: _____ Time: _____ AM / PM

Signature: _____
(Patient/representative/spouse/financially responsible party)

If signed by someone other that the patient, state your legal relationship to the patient:

_____

Witness: _____
(Hospital Representative)

Tri-City Medical Center
4002 Vista Way • Oceanside • 92056

CONSENT TO PHOTOGRAPH AND AUTHORIZATION FOR USE OR DISCLOSURE

Affix Patient Label

WHITE – Chart YELLOW – Patient

7429-____ (04/06)

Consent to Photograph / Video Form 2014

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

Consent to Photograph/Video Form

The terms photograph and/or video as used in this agreement shall mean any recording identifying an individual or group's name, image or likeness, including but not limited to video, still photography, sketch or any other electronic or mechanical means of recording and/or reproducing images. This also includes all social media platforms & website.

The undersigned hereby authorizes Tri City Healthcare District, it's employees or agents on behalf of Tri-City Medical Center (individually or together as "Hospital") to photograph or permit other persons to photograph/video:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please write legibly the name of Patient, Visitor, Employee, Medical Staff, Auxiliary Member in the above spaces. One form per family may be used. Please list names and relationship next to your name.

The undersigned agrees that the Hospital, news media personnel or any other marketing agent or publisher may use and permit its employees and associates to use such photographs or videos, including the negatives or reproductions for purposes such as educational, scientific, public relations, advertising/marketing, and charitable purposes. In doing so, the undersigned is also waiving any and all violation(s) of his/her/its Copyright or HIPAA rights. The undersigned has the right to request cessation of recording or filming at any time. The undersigned has the right to rescind consent for use at any time before the recording or film is used or distributed if made in writing to Hospital.

I am authorized and grant permission to be photographed:

Signature: _____ Date: _____

Original: Marketing Department Files

4002 Vista Way, Oceanside, California 92056 • 760-724-8411 • www.tricitymed.org

AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize Tri-City Hospital Foundation to use or disclose my health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my health care information to be released to the following recipient(s):

Name: Tri-City Hospital Foundation
4002 Vista Way
Oceanside, CA 92056

Purpose: I authorize the release of my health information for the following specific purpose:
For fundraising and advertising purposes.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ☐ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ☐ Only the following records or types of health information:
- ☐ **I authorize only the information I have provided personally and directly to the Tri-City Hospital Foundation and Tri-City Medical Center. No medical records will be requested or released by any and all providers related to my story.**

Term: I understand that this Authorization will remain in effect:
- ☐ **Until I revoke this authorization.**
- ☐ Until the Provider fulfills this request.
- ☐ Until the following event occurs:_____

Redisclosure: I understand that Tri-City Hospital Foundation cannot guarantee that the viewers of my story will not further disclose information contained in the story.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will in no way affect my relationship with Tri-City Hospital Foundation. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the Tri-City Hospital Foundation at the address listed above. The revocation will be effective immediately upon receipt of my written notice, except that the revocation will not have any effect on any action taken by Tri-City Hospital Foundation in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the Tri-City Hospital Foundation at 760-940-3520.

Signature	Date	Signature of Witness
Print Name		Witness Name

1 **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE: 10/02

SUBJECT: Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions

REVISION DATE: 06/03; 08/09; 07/12

POLICY NUMBER: 8610-276

Department Approval:	~~02/16~~ ~~(2/17)~~02/17
Administrative Policies and Procedures Committee Approval:	~~07/12~~02/~~16~~03/17
Medical Executive Committee Approval:	n/a
Pharmacy and Therapeutics (P&T) Committee Approval:	~~06/16~~05/17
Professional Affairs Committee Approval:	~~08/12~~07/17
Board of Directors Approval:	08/12

A. **PURPOSE:**

1. To provide guidelines for all Pharmaceutical waste material generated within Tri-City **Healthcare District (TCHD)**~~Medical Center~~ to be separated, stored and disposed of utilizing the appropriate waste streams stipulated by Federal, State and Local regulations.

B. **DEFINITION(S)** ~~**OF TERMS**~~**:**

1. Reverse Distributor: Vendor contracted by the Pharmacy Department to manage and process the return of expired pharmaceuticals for credit or destruction.
2. Solid Waste: Includes solid items such as paper, plastic, cardboard, glass materials, and empty PVC bags. Liquids are not allowed to be disposed as solid waste. Liquids that are NOT classified as hazardous shall be disposed down the drain.
3. Pharmaceutical Waste: **Any pharmaceutical that cannot be used for its intended purpose or returned to the manufacturer, wholesaler or reverse distributor for credit. This may include, but is not limited to:**
   - **a. Partial ampoules, vials, ointments, creams, lotions, inhalers**
   - **b. Dropped tablets or capsules, half tablets/capsules**
   - ~~3.~~**c. Patient own medications left at the hospital**
   - ~~a. Non-intact, damaged, contaminated or otherwise unwanted medications.~~
   - ~~b. Pharmaceuticals that cannot be returned to a reverse distributor for credit from the manufacturer. Examples: Half tablets/capsules, soiled (dropped) tablets/capsules, antibiotics, used Duragesic® patches, propofol, botox, oral liquids that can't be returned for credit, partial tubes of creams, ointments, used eye/ear drops, partial vials, herbals, OTCs.~~
   - ~~c. Sharps incidental to the administration of non-hazardous pharmaceutical waste may be disposed of in the non-hazardous pharmaceutical waste container.~~
4. Pharmaceutical Liquid Waste: 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.~~
5. ~~Expired Unusable Pharmaceuticals: Intact expired or unusable medications including controlled drugs.~~
6. ~~5.~~ Trace ~~Bioh~~**H**azardous Chemotherapy Waste ~~(U-listed drugs):~~ Chemotherapy contaminated items containing ~~such a~~ **equal to or less than 3% by** volume ~~that cannot be poured or scraped~~ and any products incidental to the preparation and administration that contain only residual amounts

of anti-neoplastic drugs. Includes empty vials, ampules, IV bags, as well as syringes, gloves, gowns, tubing, absorbent pads, etc. contaminated with chemotherapy substances.

~~7.~~**6.** Bulk Chemotherapy Waste ~~(U-listed drugs):~~ All containers (vials, bags, syringes, etc.) containing **chemo waste that exceeds 3% by volume** ~~such a volume that can be poured or scraped.~~ Inclusions: Chest tube chemotherapy drainage/intraperitoneal chemotherapy drainage.

~~8.~~**7.** Hazardous Pharmaceutical Waste (~~Non-chemotherapy or P-listed drugs~~**Resource Conservation and Recovery Act (RCRA)**: As defined by Federal Regulations waste, which is listed in 40 CFR 261 or is characteristically hazardous. A brief description of the characteristics includes the following:

a. Ignitability: Liquids having a flash point at < 60 degrees C, mixtures containing > 24% alcohol, Examples: rubbing alcohol, absolute alcohol, flexible collodion, ~~wart removers~~, tinctures, spirits and aerosols containing flammable propellants (this includes ~~most~~ **some** metered-dose respiratory inhalers e.g.: albuterol, Atrovent etc.).

b. Corrosivity: Aqueous solutions having a pH less than ~~or equal to~~ 2 or greater than ~~or equal to~~ 12.5. Examples: strong acids and bases- hydrochloric acid and **glacial** acetic acid.

c. Reactivity: ~~Unstable, react violently with water or are capable of detonation when heated under confinement.~~**Liable to explode, or to react violently or release toxic gases if it comes in contact with water.** Examples: ~~undiluted nitroglycerin preparations.~~**ethylene oxide**

d. Toxic Products: **Determination based on the extent to which toxic materials can leach out of the waste if they are exposed to water in the environment.** Waste designated as toxic by **United States Environmental Protection Agency** (USEPA) pursuant to 40 CFR sections 261.11. Examples: chloroform, lindane, undiluted non-admixed epinephrine, nicotine, warfarin.

e. Any commercial chemical product listed in CFR section 66261.33 having the generic name listed (e) or (f) of that subsection. This refers to a chemical substance which is manufactured or formulated for commercial or manufacturing use which consists of the commercially pure grade of the chemical, any technical grades of the chemical that are produced or marketed, and all formulations in which the chemical is the sole active ingredient.

C. **POLICY:**

1. The following types of waste shall be handled as follows:
2. Solid Waste**:**
   a. Waste container: regular wastebaskets.
   b. **Container** Label: None
   c. Liquids are not allowed to be disposed as solid waste. Liquids that are NOT classified as hazardous shall be disposed down the drain, their containers disposed in regular wastebaskets.
3. Pharmaceutical Waste**:**
   a. Waste Container: A leak-proof, puncture proof (may be used for sharps) container designed to maintain security of the wasted medication.
   b. **Container** Label: All sides of the container, including the lid, must contain the statement "Incinerate Only". The container label will contain a space to manually enter an accumulation start date and a disposal date. The accumulation date will not exceed 90 days in the pharmacy storage area.
   c. Responsible Parties: When container is full or reaches the 90-day limit, it is sealed, removed by Environmental Services or other designated personnel. Environmental Services or other designated personnel will leave a new container and enter a new accumulation date on the container label.
   d. In non-secure patient care areas, i.e. without locked medication storage area, the container must be secured to prevent diversion of contents.
4. Pharmaceutical Liquid Waste**:**
   a. May be disposed of down the sink and into the sewer.
5. Intact Expired Unusable Pharmaceuticals**:**

a. Intact expired or unusable medications including controlled substances are collected from all pharmacy drug storage areas, by pharmacy or other designated personnel, segregated from intact, usable pharmaceuticals and stored for pick-up by a reverse distributor with the intent to return for credit.
b. The reverse distributor shall dispose **of** those medications that are unable to be returned for credit.

6. Trace ~~Biohh~~Hazardous Chemotherapy Waste (**also known as**~~AKA:~~ ~~Biohh~~Hazardous Chemotherapeutic/Cytotoxic Waste)**:**
   a. Waste Container: A yellow, rigid, leak proof and puncture resistant container with tight fitting lid to preclude the loss of contents, used to store ~~bioh~~hazardous chemotherapeutic waste or yellow chemotherapy waste bag for soft products (ie. Gowns, gloves, tubing, etc.) **Container** Label: Facility name and address and phone number. All containers must be labeled as "Trace Chemotherapy Waste" on top and sides of container. The words "Incinerate Only" must be on the container.
   b. Responsible Party:
      i. When container is full, ~~it is~~ nursing or pharmacy staff will securely seal it. Staff will notify Environmental Services or other designated personnel for removal.
      ii. Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.
      iii. Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated ~~Biohh~~Hazardous waste storage area for removal by contracted, licensed transporter of ~~Biohh~~Hazardous Waste.
7. Bulk Chemotherapy Waste (~~AKA:~~**also known as** Hazardous Chemotherapeutic/Cytotoxic Waste)
   a. Waste Container: A ~~yellow, rigid, leak proof and puncture resistant~~**black, rigid, leak proof and puncture resistant RCRA** container with a tight fitting lid, to preclude loss of contents. The accumulation start date ~~for~~ will be posted on the container.
   b. **Container** Label: Bulk chemotherapy waste containers shall have a "hazardous waste" label affixed with all required information entered including the following:
      i. Facility name and address and phone number
      ii. A large yellow label will be affixed with the title "HAZARDOUS WASTE, State and Federal Law Prohibits Improper Disposal", and includes the statement: "PROPERTIES/ DESCRIPTION: CHEMOTHERAPY WASTE".
      iii. Date accumulation was started for container. Total accumulation period per container may not exceed 90 days in the pharmacy storage area if facility is classified as a Large Quantity Generator or 180 days in the designated storage area if facility is classified as a Small Quantity Generator.
      iv. Responsible Party:
         1) When container is full, or no greater than 180 days, nursing or pharmacy staff will securely seal it. Staff then notifies Environmental Services or other designated personnel for removal.
         2) Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.
         3) Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated Hazardous Materials storage area, where it will remain until removed from premises by licensed, hazardous waste transporter.
8. Hazardous Pharmaceutical Waste (~~Non-chemotherapy/~~RCRA)**:**
   a. Waste Container: A black, rigid, leak-proof and puncture resistant container with a tight fitting lid.
   b. Label: Facility name, address and phone number. All containers must be labeled with a red and white label that states "RCRA Hazardous Waste" on side of container.
   c. Non-chemotherapy Hazardous Waste must be segregated from bulk chemotherapy waste.

~~d. All shipments for disposal of bulk hazardous waste must be manifested as hazardous waste. When the carrier destroys the hazardous waste, a certificate of destruction (manifest) will be returned to engineering **the Safety Officer** to be kept with the original manifest.~~

9. Controlled Substance Waste:

a. RX Destroyer Waste Container: A rigid, leak proof container with a tight fitting lid.

b. Responsible Party:

i. When container is full, nursing or pharmacy staff will securely seal it. Staff will notify Environmental Services or other designated personnel for removal.

ii. Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.

iii. Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated Hazardous waste storage area for removal by contracted, licensed ~~transporter.~~waste hauler.

~~9.~~**10.** Quality Assessment/Compliance Measurement:

a. Depending on the entity, any one or combination of the following quality assessment/compliance measurement may be used to facilitate waste stream compliance:

~~a.~~**i. Waste grids listing disposal pathways will be posted in medication areas.**

~~i.~~**ii.** Pharmaceutical waste containers will be routinely inspected. EVS will be called for removal/replacement when full or expiration date is reached.

~~ii.~~**iii.** The EVS ~~Director~~ **Manager** or Designee will perform a weekly inspection for expiration date and fullness of pharmaceutical containers.

~~iii.~~**iv.** EOC/Safety Officer will include container inspection during ~~monthly~~ **routine** inspections of drug storage areas.

~~iv.~~**v.** During ~~Hazardous Surveillance~~ inspection of Drug Storage Areas assessment of appropriateness of the pharmaceutical waste stream ~~by nursing~~ will be performed.

~~v.~~**vi.** An inspection of pharmaceutical waste containers for appropriate use, expiration date and fullness will be added to the bi-annual EVS/Safety Officer hospital rounds.

~~vi.~~**vii.** Discrepancies found during inspections and rounds will be reported to Pharmacy or designated Administrator for resolution.

~~10.~~**11. Disposal of Hazardous Waste:**

a. All shipments ~~for disposal~~ ~~of bulk~~ of hazardous waste must be manifested per regulatory requirements ~~as hazardous waste~~. When the carrier destroys the hazardous waste, a certificate of destruction (manifest) will be returned to ~~engineering~~ the Safety Officer to be kept with the original manifest.

D. **RELATED DOCUMENT(S):**

1. **Waste Disposal Guidelines**

E. **REFERENCE(S):**

1. Medical Waste Management Act Sections 117600 – 118360
2. "Controlling Occupational Exposure to Hazardous Drugs" OSHA Instruction CPL 2-2.20B
3. Ch-4, 4/14/95, Directorate of Technical Support
4. Title 22, Division 4.5, Chapter 11, Article4, Section 66261.32, Section 66261.33, Section 66261.24
5. Code of Federal Regulations, Section 261.24
6. J. Barnard, The New Pharmaceutical Waste Disposal Requirements, California Pharmacist, Winter 1997:22-24
7. **http://www.gpo.gov/fdsys/pkg/CFR-2014-title40-vol26/pdf/CFR-2014-title40-vol26-sec261-24.pdf**
8. **https://www.fda.gov/RegulatoryInformation/Legislation/ucm148726.htm#**

TCMC Waste Disposal Guidelines

						 
Regular Waste NO NEEDLES	**Biohazardous Waste** NO NEEDLES	**Sharps** NEEDLES OK	**Pharmaceuticals** NEEDLES OK	**Controlled Substances** NO NEEDLES	**RCRA Pharmaceuticals** NO NEEDLES	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ **All sharps** *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** *Examples:* ▫ *Insulin/Insulin Pen (needles removed)* ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Used & Unused nicotine gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** **Return to pharmacy all** unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual

DELETE – Combined policy with Policy 8610-622, Electronic Health Record (Cerner) Access, Physicians and Physicians Office Employees.

ISSUE DATE: 3/04

SUBJECT: Remote Access: Physicians and Physician Office Employees

REVISION DATE: 2/05

POLICY NUMBER: 8610-620

Department Approval Date(s):	~~04/16~~05/17
Administrative Policies & Procedures Committee Approval:	~~11/08~~06/17
~~Operations Team Committee Approval:~~	~~12/08~~
Professional Affairs Committee Approval:	~~01/09~~07/17
Board of Directors Approval:	01/09

~~A. **PURPOSE:**~~

~~1. To provide Remote Access to Tri-City Healthcare District's (TCHD) Clinical Information System (Compass) and other TCHD applications, while meeting audit and regulatory requirements for confidentiality and security of information, to each Authorized Physician or Physician Office Employee associated with the TCHD.~~

~~B. **DEFINITIONS:**~~

~~1. Compass: TCHD's clinical information system.~~

~~2. Remote Access: Physician devices, from home or office, which access Compass and other TCHD applications.~~

~~C. **POLICY:**~~

~~1. Remote Access is provided to Authorized Physicians or Physician Office Employees associated with the TCHD.~~

~~2. A Physician Office Employee may be granted Remote Access upon request from the employing physician. Access by a Physician Office Employee is restricted to only the assigned patients of the physician or group by which they are employed.~~

~~3. Each Authorized Physician or Physician Office Employee has a responsibility to use Remote Access in a legal manner.~~

~~4. All TCHD policies and practices apply to Remote Access, including those policies regarding intellectual property protection, privacy, misuse of TCHD resources, sexual harassment or other unlawful harassment, information and data security, and confidentiality.~~

~~5. Each Authorized Physician or Physician Office Employee is provided with a written copy of this policy. Each Authorized Physician or Physician Office Employee must complete and sign the Remote Access Agreement.~~

~~6. While Remote Access offers significant benefits, it can also expose the TCHD computer systems to risks and compromise if appropriate security measures are not strictly followed. Each Authorized Physician or Physician Office Employee is personally accountable for any action that results in a breach of TCMC security or confidentiality.~~

~~7. An Authorized Physician or Physician Office Employee User must not use Remote Access to knowingly violate the laws and regulations of the United States or any other nation.~~

~~8. Access for each Physician Office Employee is categorized by the clinical or administrative duties, to ensure that access is limited to appropriate types of patient information.~~

~~D. **PROCEDURE:**~~

~~1. An Authorized Physician or Physician Office Employee who has a legitimate need for Remote Access should request it in the following manner:~~

~~a. Obtain a Remote Access Agreement from the TCHD Information Technology~~

Department.

b. Submit the completed and signed Agreement to the Information Technology Department.

c. Each Authorized Physician or Physician Office Employee is assigned a TCHD Network Login and Password. No generic or multi-user network logins are permitted and sharing of passwords are strictly prohibited. If a Physician has multiple employees authorized for Remote Access, it is the responsibility of that Physician to notify the Information Technology Department of any changes (new employees, terminated employees, change in employee classification)

d. An Information Technology representative will provide instructions to the requestor.

E. **MANAGEMENT AND ADMINISTRATION:**

1. The TCHD Information Technology Department is responsible for assuring security of the TCHD network. The Information Technology Department must approve all requests for Remote Access.
2. The Information Technology Department will provide instructions regarding the Remote Access method to connect to the TCHD Network. Each Physician or Physician Office Employee is entrusted with access to the TCHD Network, and this is the sole method to be used to connect to the Network. Each Physician or Physician Office Employee will receive instructions from the Information Technology Department regarding security controls for Remote Computing. The Physician or Physician Office Employee must secure the Remote Desktop PC according to directions provided by the Information Technology Department.
3. To access the TCHD Network, the Physician or Physician Office Employee may have to access the Internet. While the TCHD Information Technology Department provides security controls for Network access, there are many potential dangers inherent in Internet access. Each Physician or Physician Office Employee will receive guidance from the Information Technology Department regarding the use and regular updating of anti-virus and firewall software to protect the Remote Desktop PC.
4. The TCHD Information Technology Department provides software virus protection. Notify the Information Technology Department immediately if a software virus is detected.
5. Remote control software, such as PC Anywhere, is prohibited from being installed on any Remote Access workstation without the prior approval of the TCHD Information Technology Department.
6. Physicians or Physician Office Employees should use Remote Access as intended by the assigned Login and Password. COMPASS files are not to be sent to the Physician Office or any external entity unless approval and assistance is obtained from the TCHD Information Technology Department.
7. TCHD has installed a variety of firewalls, proxies, and Internet address screening programs and other security systems to assure the safety and security of the networks. Any Physician or Physician Office Employee who attempts to disable, defeat, or circumvent any security facility will be subject to appropriate corrective action as defined by policies.
8. Adherence to this Remote Access policy is neither voluntary nor optional. Violation of this policy could lead to disciplinary action based on guidelines established in the Medical Staff Bylaws. If necessary, TCHD also reserves the right to advise appropriate legal officials of any illegal violations (Legal Notice – California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony). Each Physician or Physician Office Employee is expected to report unauthorized use or violation of this policy to a TCHD Vice President or to the Information Technology Department.
9. Physicians are responsible for notifying the Information Technology Department whenever a physician office employee is no longer employed by their office in order to disable the user login.
10. The Medical Staff Department is responsible for notifying the Information Technology Department if a physician is no longer authorized to access Compass.

F. **ENFORCEMENT:**

1. ~~Unauthorized Remote Access may be discovered via system monitoring, audit reports, or observation of others.~~
2. ~~A TCHD Vice President or the Director, Information Technology Department who receives a report of unauthorized use or violation of this policy, will submit a request for an investigation, in writing, to the Medical Executive Committee, with supporting documentation, referencing the specific activities or conduct alleged. Recommended Violation Levels and Action Steps are listed on page 4.~~

RECOMMENDED VIOLATION LEVELS

If necessary, TCMC reserves the right to advise appropriate legal officials of any illegal violations. Legal Notice - California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

Level and Definition of Violation	Examples of Violations	Recommended Action
Accidental violation due to lack of proper education	• Failing to sign off a PC when not using it • Accessing own record in COMPASS	• Retraining and re-evaluation • Discussion of policy and procedures • Oral warning, reprimand, or notification
Purposeful violation or an **unacceptable number** of previous violations	• Accessing the record of a patient without having a legitimate reason to do so • Using another user's access code • Allowing another user to access COMPASS via your password	• Retraining and re-evaluation • Discussion of policy and procedures • Written warning and acknowledgment of consequences of subsequent infractions
Continued purposeful violation, an **unacceptable number** of previous violations and/or **unauthorized disclosure** of COMPASS Information	• Accessing the record of a patient without having a legitimate reason to do so • Using another user's access code • Allowing another user to access COMPASS via your password • Disclosure of confidential patient information • Disclosure of confidential TCMC financial information	• Revocation of Medical staff privileges • Possible legal action

TRI-CITY HEALTHCARE DISTRICT

REMOTE ACCESS REQUEST FORM
Physician or Physician Office Employee

LAST NAME: _____

FIRST NAME: _____ **MIDDLE INITIAL:** ____

I will use Remote Access as intended by my assigned Login Name and Password. I understand that all messages and records of COMPASS and other are official records and are the property of the Tri-City Healthcare District (TCHD), which reserves the right to access and disclose, at any time, all Remote Access documentation.

TCHD has installed a variety of firewalls, proxies, and Internet address screening programs and other security systems to assure the safety and security of the networks. I will not attempt to disable, defeat or circumvent any security facility.

I understand that it is important to maintain a secure password. I will not share my password with anyone, nor will I reveal my password to anyone via email or phone. If I believe that someone has learned my password, I will immediately change the password and report the incident to the Information Technology Help Desk.

I understand that violation of these rules is grounds for corrective action. If necessary, TCHD reserves the right to advise appropriate legal officials of any illegal violations. California Penal Code 502 states that unauthorized use of a computer in the state of California is a felony.

I will report any unauthorized use of COMPASS to the Information Technology Department.

I have received a written copy of the TCHD's Information Technology Policy 620. I fully understand the terms of this Policy and agree to abide by them.

_____ _____

SIGNATURE – Physician or Physician Office Employee Date

_____ _____

SIGNATURE - TCHD Vice President Date

FOR INFORMATION TECHNOLOGY DEPARTMENT USE ONLY

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Patient Care

ISSUE DATE:	**05/86**	**SUBJECT:**	**Reporting Suspected Child Abuse/Neglect**
REVISION DATE:	**08/94; 02/96; 01/97; 07/99; 04/02; 06/03; 12/05; 04/09; 06/11**	**POLICY NUMBER:**	**8610-308**

Department Approval:	**04/17**
Clinical Policies and Procedures Approval:	**05/17**
~~**Administrative Policies & Procedures Approval:**~~	~~**05/11**~~
Nurse Executive Council Approval:	~~**06/11**~~**05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	~~**06/11**~~**07/17**
Board of Directors Approval:	**06/11**

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected child abuse and neglect cases.

B. **DEFINITIONS:**

1. Child – Person under the age of 18.
2. Mandated Reporter - **Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, or licensed nurses.**~~Includes an administrator or employee of Tri-City Medical Center, social worker, physician, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, other licensed professionals under the California Business and Professions Code, EMT, paramedic, a clergy member, and alcohol and drug abuse counselor **who has knowledge of or observes a child in his/her professional capacity or with the scope of his/her employment whom he/she or know or reasonably suspects has been the victim of child abuse or neglect, to report such suspected instances to the designated agency** .~~
3. Abuse **or neglect** – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, pinching or kicking. Also includes controlling behavior through **unlawful** corporal punishment.
   c. Sexual Abuse – Includes sexual assault and sexual exploitation.
   ~~d. In situations occurring outside the home where child abuse or neglect is suspected and the person responsible for the child's welfare is a licensee, administrator, or employee of a child care facility, private or public residential home, school, or other institution.~~
   ~~4.~~**d.** Emotional Damage – when a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage**, evidenced by states of being or behavior, including but not limited to,**~~ such as~~ severe anxiety, depression, withdrawal or **untoward** aggressive behavior toward self or others.
   ~~5.~~**e.** Neglect – **the negligent failure or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the**

part of the responsible person.~~It also may include placing the individual in unsafe or unsupervised conditions.~~

i. **General Neglect - the negligent failure of a person having the care or custody of a child to provide** ~~The absence of minimal services or resources to meet basic needs. Neglect includes withholding or providing in~~adequate food~~and hydration (without physician, patient, or surrogate approval,~~) clothing, **shelter,** medical care **or** ~~, and good hygiene~~**supervision where no physical injury to the child has occurred**.

~~6.~~ii. **Severe Neglect - the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non organic failure to thrive. It also means those situations of neglect where the person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that the child's person or health is endangered.**

~~7.~~**f.** Willful cruelty or unjustifiable punishment - A situation where a person willfully harms or injures a child or causes or permits a child to suffer or inflicts unjustifiable physical pain or mental suffering upon the child or permits a child to be placed in a situation where the child's person or health is endangered.

g. Unlawful corporal punishment or injury - a situation where a person willfully inflicts upon a child cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

h. Reasonable Suspicion – for purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. For purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

~~8.~~**i. Note: Child abuse does not include a mutual affray between minors or an injury** caused **by a peace officer's reasonable and necessary force used while acting within the course and scope of the officer's employment as a peace officer. Affray is not defined in the law, but the dictionary defines it is a fight, quarrel or brawl.**

C. **POLICY:**

1. Under Sections 11166 of the California Penal Code, mandated reporters ~~must make a report to a child protective services agency~~ **and**~~or~~ **the** ~~local law enforcement agency~~ **who has knowledge of or observes a child** ~~when~~ in his/her professional capacity or within the scope of his/her employment ~~has knowledge of, or observes, a child~~ whom **he/she**~~the mandated reporter~~ knows~~,~~ or reasonably suspects, has been the victim of child abuse or neglect**, to report such suspected instances to the designated agency**. The initial report must be made immediately, or as **practically possible**~~soon as practicable~~, by telephone and followed up with a written report within thirty-six (36) hours. A mandated reporter may report suspected emotional damage under Section 11166.05 of the California Penal Code.
2. The following criteria may indicate a need for further assessment. Criteria may include the following:
   a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches).
   b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
   c. Poor hygiene, malnourishment.
   d. Fear of parent or caregiver, being withdrawn or tearful.
   e. Inappropriate responses to questions about a safe environment or being threatened at

home.

~~e.~~**f. Home or institution in which child resides is unsuitable for the child because of abuse or neglect.**

3. This law relates to any person under the age of 18 years whose home is an unfit place for him/her, by reason of neglect, cruelty, depravity or emotional abuse by either parent, guardian or other person in whose custody or care he/she resides.
4. If a minor seeks treatment for pregnancy, an abortion, sexually transmitted disease or birth control assistance, a report is not indicated unless there is evidence or reasonable suspicion to believe that a sexual assault, sexual abuse, or other abuse or neglect has occurred. (Pregnancy in a mentally or physically impaired or mentally compromised child does raise a reasonable suspicion of child abuse).
5. If voluntary sexual activity exists between minors who are of disparate ages and one of the minors is under 14 years of age, or, one party is a minor and the other is over age 21, or, any relationship in which it appears that a minor is being manipulated or exploited, a report of child abuse is required.
6. All cases of child abuse suspected by any mandated reporter must be reported in the following manner:
   a. Children Services 24 hour Child Abuse Hotline number: (1-800-344-6000).
   b. Complete the SS 8572 suspected child abuse reporting form within 36 hours of a telephone report and forward it to the hospital Social Services Department to be mailed and a copy filed.
7. Use a FAX Report: Monday - Friday, 0800 to 1700 only. (Do not send an SS 8572 if the FAX Report has been sent).
8. Use the Children's Services Child Abuse Hotline 1-800-344-6000 between 1700 and 0800, on weekends, and on holidays to make telephone reports. Complete the SS 8572 in addition to the phone call and forward the SS 8572 to the hospital's Social Services Department.
9. Upon reporting suspected child abuse, the county caseworker or child protective worker will instruct the hospital whether or not to place a 48 hour "hold" on said child. The court hold is usually placed as a means of providing protective custody and ensuring that the child will be given proper medical treatment. The "hold" shall be released within 48 hours, excluding non-judicial days, after the minor has been taken into custody, unless within said period of time a petition is filed with the Juvenile Court for a detention hearing. If a petition is filed with Juvenile Court, the child shall remain in custody until which time the "detention hearing" has transpired. At that time, the physician or District will act in accordance with court orders from said hearing.
10. The mandated reporter involved in evaluation, collection of facts and information, and reporting has the responsibility of ensuring such information is documented in writing in the medical chart in a comprehensive manner.
11. A mandated reporter shall inform the legal guardian of said "suspected" abused child of what actions have taken place, why they transpired, and what position the hospital must take in such situations as prescribed by law.
12. The Social Services Department at the hospital has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency as well as notification of the TCHD Compliance Officer. This applies whether seen in the Emergency Department or admitted to the Medical Center.
13. Social Services Department will be notified of all cases of suspected child abuse by one of the following methods:
    a. Making a Social Services referral through the computer.
    b. By telephone to the Social Services department or page to a specific Social Worker.
    c. By completing an SS 8572 Child Abuse Reporting Form and forwarding it to the hospital Social Services Office.
    d. By completing a Child Protective Service fax form and forwarding it to the hospital Social Services office.
14. The Clinical Social Worker shall serve as the communication link between the District and outside agencies regarding compliance with stated child abuse statutes and the regulations and procedures of the San Diego County Health and Human Services Agency, Children Services.

15. In the event that a child is to be discharged from the hospital while deemed in the custody of the Juvenile Court, the Clinical Social Worker or designee will coordinate such discharge by requiring proper identification from the person to whom the child is being discharged; and will request that court documentation of detention and custody be provided or mailed to the District as soon as possible.
16. Copies of all completed Child Protective Service fax forms and Child Abuse Reporting Forms (SS 8572) will be filed in the Social Services Department at the hospital.
17. Any problematic cases are reported to the Director/Manager of Social Services and Director of Legal Services/Risk Management for additional review.
18. Penal Code Section 11172 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.
19. When two or more mandated reporters have knowledge, or reasonably suspect, a reporting incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.
20. Any person who is not a mandated reporter who knows, or reasonably suspects, that a child has been the victim of abuse, may report that abuse. Such report may be coordinated through the Social Services Department.

D. REFERENCES:

~~D.~~1. **California Hospital Association. (20176). *California Hospital: Consent Manual.* CHA Publications: Sacramento.**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Patient Care

ISSUE DATE: 05/86

SUBJECT: Reporting Suspected Dependent Adult/Elder Abuse/Neglect

REVISION DATE: 06/91, 09/94, 02/96, 01/97, 07/99, 10/00, 06/03, 12/05, 04/09, 06/11

POLICY NUMBER: 8610-309

Department Approval:	**04/17**
Clinical Policies and Procedures Committee Approval:	**05/17**
~~**Administrative Policies & Procedures Approval:**~~	~~**05/11**~~
Nurse Executive Council Approval:	~~**06/11**~~**05/17**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	~~**06/11**~~**07/17**
Board of Directors Approval:	**06/11**

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected abuse/neglect of elders and dependent adults.

B. **DEFINITIONS:**

1. Abandonment:
   a. Desertion of willful forsaking of an elder or dependent adult by anyone having care of custody of that person under circumstances in which a reasonable person would continue to provide care **and custody**.
2. Abuse:
   a. ~~The following are various types of abuse:~~**means** ~~P~~**p**hysical **abuse**, neglect, financial **abuse**, abandonment, isolation, abduction, or other treatment resulting in harm, pain or mental suffering or deprivation by a care custodian **of goods and services** ~~, staff, other patients, physicians or visitors~~ **that are necessary to avoid physical harm or mental suffering**.
3. Dependent Adult:
   a. Anyone between the ages of 18 and 64 years who has physical or mental limitations or age-diminished physical or mental abilities which restrict that person's ability to carry out normal activities or to protect his/her rights **including (but not limited to) persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age**. This definition also includes any one between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital or other 24-hour health facility.
4. Elder:
   a. Any person 65 years of age or older.
5. **Endangered Adult**:
   a. Means a dependent or elder adult who is at immediate risk of serious injury or death, due to suspected abuse or neglect and who demonstrates the inability to take action to protect himself or herself from the consequences of remaining in that situation or condition
6. ~~Finanacial~~**Financial Abuse:**
   a. **Occurs when a person or entity takes, secrets**~~secretes~~**, appropriates, obtains, or**

retains (or assists another to do so) real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud or both, or by undue influence

7. Exploitation:
   a. An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
8. Imminent Danger:
   a. Substantial probability that elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his/her own action or inaction or as a result of the action or inaction of any other person.
9. Isolation:
   a. Acts to intentionally prevent an elder or dependent adult from receiving mail or phone calls.
   b. Telling a caller or prospective visitor that an elder or dependent adult is not present, does~~Preventing family, friends, or concerned persons from visiting with the elder or dependent adult which is contrary to the wishes of that person, whether they are competent or not.~~**:**
      i. False
      ii. Contrary to the express wishes of the elder or dependent ~~adulot~~**adult, whether he or she is competent or not; and**
      ~~b.~~**iii. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons**
   c. False imprisonment.
   d. Physical Restraint **of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors**
10. Mandated Reporter:
   a. **Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, or licensed nurses**~~Includes any person responsible for care or custody of an elder or dependent adult including administrators, supervisors, any licensed staff of a facility that provides care or service, or any care custodian or health practitioner~~.
11. Mental Suffering:
   a. Fear, agitation, confusion, severe depression or other forms of serious emotional distress brought about by threats, harassment, or other forms of intimidating behavior.
   ~~11.~~**b. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult**
12. Neglect:
   a. The negligent failure of a person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or~~The absence of minimal services or resources to meet basic needs.~~
   b. The negligent failure of an elder or a dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise
   ~~12.~~**c.** Neglect includes:
      ~~a.~~**i.** Failure to assist in personal hygiene, or in provision of food, clothing or shelter
      ~~b.~~**ii.** Failure to provide medical care for physical and mental health needs (excludes the elder or dependent adult who voluntarily relies on treatment by spiritual means vs. medical treatment, when no other indicators of abuse exist)
      ~~i.~~**iii.** Failure to protect from health and safety hazards
      ~~ii.~~**iv.** Failure to prevent malnutrition or dehydration
   ~~c.~~**d. If a person cannot** ~~Failure to be able to~~ provide the above for oneself **due to** ~~as a result of~~ poor cognition functioning, mental limitation, substance abuse, or **chronic** poor

health**, this also constitutes neglect**

13. Physical Abuse: **means all of** ~~may include~~ the following:
    a. Assault
    b. Battery
    c. Assault with a deadly weapon or force likely to cause great bodily harm
    d. Unreasonable physical constraint, or prolonged or continual deprivation of food or water
    e. Sexual assault **which means any of the following**~~or~~**:**
        ~~e.~~**i.** **Sexual** battery
        ~~i.~~**ii.** Rape
        iii. **Rape in concert**
        ~~ii.~~**iv.** **Spousal rape**
        ~~iii.~~**v.** Incest
        ~~iv.~~**vi.** ~~Forced s~~**S**odomy
        vii. ~~Forced o~~**O**ral copulation
        viii. **Sexual penetration**
        ~~v.~~**ix.** **Lewd or lascivious act**
    f. ~~Inappropriate u~~**U**se of physical or chemical restraint, or ~~Inappropriate use of~~ psychotropic medication **under the following conditions**
        i. ~~f~~**F**or punishment~~or~~
        ~~f.~~**ii.** **For a period significantly beyond that for which the restraint or medication is authorized by**~~inconsistent with treating~~ **a** physician's **licensed in California** ~~who~~**who is providing medical care to the elder or dependent adult at the time the instructions are given**~~orders~~
        ~~g.~~**iii.** **For any** ~~purspose~~**purpose not authorized by the physician**~~Misuse and abuse of drugs/medications~~

C. **POLICY:**

1. Sections 15600, et seq., of the California Welfare and Institutions Code requires that a mandated reporter who, in his/her professional capacity, or within the scope of his/her employment that has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he/she has experienced behavior, including the act or omission, constituting acts described above, shall report to an adult protective services agency or local law enforcement agency by telephone immediately or as soon as practicably possible, and by written report within two (2) working days.
2. The following may indicate a need for further assessment:
    a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches)
    b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks)
    c. Poor hygiene, malnourishment
    d. Fear of parent or caregiver, being withdrawn or tearful
    e. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
    f. Inappropriate responses to questions about a safe environment or being threatened at home
3. The code also permits the reporting of suspected intimidation, cruel punishment, or other treatment that endangers an elder or dependent adults' emotional well-being.
4. Instances do not have to be reported if a physician, registered nurse, or psychotherapist are unaware of independent evidence of incidents described in 1 above, and the patient has been diagnosed with a mental illness or dementia and mandated reporter does not believe abuse occurred.
5. Abuse of an elder or dependent adult is a criminal act.
6. Welfare and Institutions Code Section 15634 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.

7. Any person who knowingly fails to report an instance of elder or dependent adult abuse is guilty of a misdemeanor.
8. The mandated reporter will complete an assessment and report the findings to the attending physician. If abuse is suspected, the mandated reporter will make a telephone report to the appropriate agency immediately or as soon as practically possible.
   a. If the alleged abuse occurred in a long-term care facility (Skilled Nursing Facility or Board & Care), the report must be made to the local ombudsman (1-800-640-4661; fax 858-694-2568) or the local law enforcement agency where the incident occurred.
   b. If the alleged abuse occurred anywhere else, the report must be made to the County Aging and Independence Services (AIS) at 800-510-2020.
   c. The mandated reporter will notify by phone, the adult abuse hotline (AIS) at 800-510-2020, or the ombudsman's office 1-800-640-4661 and will complete the elder abuse reporting form SOC 341.
9. The mandated reporter making the telephone report must complete a written report and mail it to the appropriate agency within two (2) working days of making the telephone report.
10. All completed SOC 341 forms need to be forwarded to the hospital Social Services Department for mailing and filing. Copies of all completed "Suspected Dependent Adult/Elder Abuse" forms (SOC 341) will be filed and maintained in the Social Services Department at TCHD.
11. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
12. Social Services Department will be notified of all cases of suspected elder abuse/neglect by one of the following methods:
    a. Making a Social Service referral through the computer.
    b. By telephone to the Social Services department or page to a specific Social Worker.
    c. By completing an SOC 341 Elder Abuse Reporting Form and forwarding it to the hospital Social Services Office.
13. Detention of Endangered Adults - Welfare and Institutions Code Section 15703.05 allows a physician treating an adult, if he/she determines that adult is endangered, to delay the release until:
    a. A local law enforcement agency takes custody of the patient
    b. The responding agency determines the adult is not an endangered adult
    c. The responding agency takes other appropriate action to ensure the safety of the endangered adult (This law applies whether or not medical treatment is required)
14. **If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:**
    a. The health care provider believes, in the exercise of professional judgement, that the informing the patient would place him or her at risk of serious harm, or
    b. The health care provider would be informing a personal representative , and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient
    c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.

~~14.~~**15.** When appropriate, the Clinical Social Worker shall inform the patient and/or family of what actions have taken place, why they transpired, and what position the District must take in such situations as prescribed by law.

~~15.~~**16.** The Clinical Social Worker shall serve as liaison between the District and all outside agencies, in compliance with Elder/Dependent Adult Abuse statutes and the regulations and procedures of San Diego County Department of Social Services.

~~16.~~**17.** The Clinical Social Worker may continue to provide case management including discharge

planning to a safe environment.

~~17.~~**18.** Any problematic cases are reported to the Director/Manager of Social Services and the Director of Risk Management for additional review.

~~18.~~**19.** When two or more mandated reporters have knowledge or reasonably suspect a reportable incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.

~~19.~~**20.** Any person who is not a mandated reporter who knows, or reasonably suspects, that an elder or dependent adult has been the victim of abuse, may report that abuse. Such reports may be coordinated through the Social Services Department.

D. **REFERENCE(S):**

1. **California Hospital Association. (2017~~6~~). *California Hospital: Consent Manual.* CHA Publications: Sacramento.**

Tri-City Medical Center
Oceanside, California

Infection Control ~~Manual~~Policy

ISSUE DATE: 09/00

SUBJECT: Epidemiologic Investigation of a Suspected Outbreak

~~**Next review date: 7/2017**~~
REVISION DATE(S): 03/02, 03/05, 07/14

Standard Number: IC. 3

Infection Control Department Approval:	**~~07/14~~03/17**
Infection Control Committee Approval:	**~~07/14~~04/17**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/14~~06/17**
Professional Affairs Committee Approval:	**~~08/14~~07/17**
Board of Directors Approval:	**08/14**

A. **PURPOSE:**

1. To provide guidelines for uniform and complete investigation of suspected outbreaks of healthcare associated infections (HAI) or community acquired infections seen in the hospital.

B. **POLICY:**

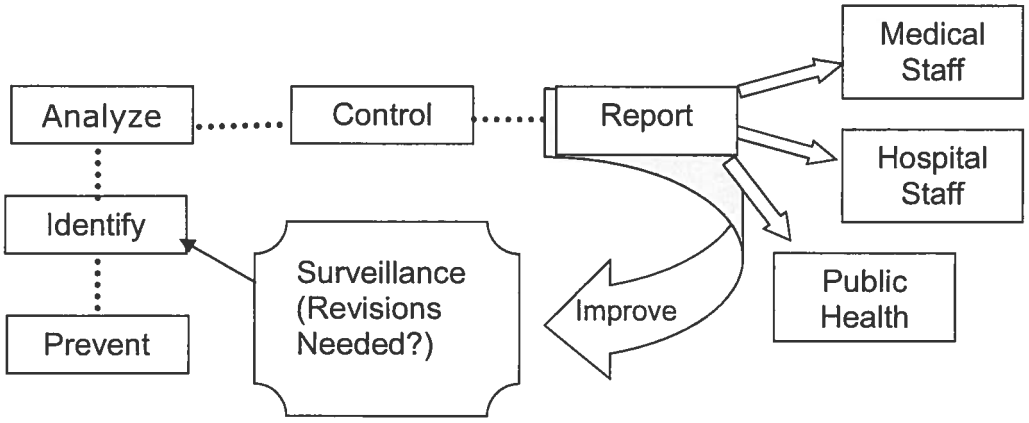
1. The Infection Control Committee shall have ultimate responsibility for investigating outbreaks and developing policies aimed at prevention and control of healthcare associated infections (HAI). If an outbreak is suspected, the hospital epidemiologist or his designee will direct the investigation. The aim of the process is to identify the source of the organism and the mode of spread so that infection control measures can be instituted to halt an outbreak.

~~1.~~**2. An outbreak is defined as an increase over the expected occurrence of an event.**

C. **PROCEDURE:**

1. The ~~hospital~~ **Medical Director of Infection Control along with the Infection Preventionist (s)** ~~epidemiologist (or designee)~~ will determine whether a situation is a probable outbreak that poses a threat to the health of patients, employees or visitors and warrant further investigation. **They**~~He~~ may elect to call an emergency meeting of the Infection Control Committee. The meeting would be called to accomplish the following:
   - ~~2.~~**a.** Clarify the nature and extent of the potential outbreak.
   - ~~3.~~**b.** Discuss proposed investigational steps.
   - ~~4.~~**c.** Determine exact criteria for selection of subjects for possible epidemiologic studies.
   - ~~5.~~**d.** Determine and assign responsibility of each department; determine who will collect and record data.
   - ~~6.~~**e.** Anticipate questions that may arise and develop consistent answers. Assign resource people to respond to queries and keep personnel informed.
   - ~~7.~~**f.** Appraise the State and local health departments of outbreaks and reportable conditions.
   - ~~8.~~**g.** Identify components of an Investigation
   - ~~9.~~**h.** Confirm that an outbreak exists.
   - ~~10.~~**i.** Establish or verify diagnosis of reported cases; identify agent and develop a case definition.
   - ~~11.~~**j.** Search for additional cases; collect critical data and specimens~~.~~ **(**~~S~~**s**ee Data Collection Tool ~~in Appendix A~~**)**.
   - ~~12.~~**k.** Characterize the cases by person, place and time; plot the epidemic curve and geographic areas that are involved.
   - ~~13.~~**l.** Analyze the data; show that the current rates are higher than pre-outbreak rates.
   - ~~14.~~**m.** Perform a literature review.

~~15.~~**n.** Communicate with department heads, microbiology director, administrators, and employee health as appropriate.
~~16.~~**o.** Formulate tentative hypothesis; keep a diary with detailed notes about the investigation.
~~17.~~**p.** Test hypothesis.
~~18.~~**q.** Consider control measures and alternatives; institute most appropriate measures.
~~19.~~**r.** Evaluate and document efficacy of control measures.
~~20.~~**s.** Change policies and procedures if necessary.
~~21.~~**t.** Communicate findings and write report.



D. **RELATED DOCUMENT(S):**

1. **Data Collection Tool Sample**

E. **REFERENCES:**

~~1. Centers for Disease Control and Prevention, Principles of Epidemiology: An Introduction to Applied Epidemiology. 2nd ed. Atlanta: United States Department of Health and Human Services, Public Health Service, CDC; 1992.~~
~~2. Jarvis, W. R. (2004). Investigation of outbreaks. In C. G. Mayhall (Ed.), Hospital Epidemiology and Infection Control (3rd Ed.), (pp. 107-122). Philadelphia, PA: Lippincott Williams & Williams.~~
~~3. Dixon RE. Investigation of endemic and epidemic nosocomial infections. In: Bennett JV, Brachman PS, eds. Hospital Infections. 3rd ed. Boston: Little, Brown; 1992:109-134.~~

1. **Campbell, E.** ~~Srinivasan,A.~~ (201~~409~~). **Chapter 12** Outbreak Investigation. ~~In:~~ APIC Text of Infection Control and Epidemiology. Washington DC: APIC, **4th Edition.**~~.~~
2. **CDC Principles of Epidemiology: Lesson 6 Investigating an Outbreak**
3. **https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section1.html**
4. **CDC: Outbreak Investigations in Healthcare Settings**
~~4.~~**5. https://www.cdc.gov/hai/outbreaks/**

Data Collection Tool Sample

MR #	Patient's Name	Admit Date	Date of Onset of S & S	Culture Date	Culture Results	Invasive Device or Procedure	Device / Procedure Date	Unit	Comments

Tri-City Health Care District
Oceanside, California

Infection Control Policy ~~Manual~~

ISSUE DATE: 07/03 **SUBJECT:** Hand Hygiene

REVISION DATE: 04/08 **STANDARD NUMBER:** IC. 8

Department Approval:	04/17
Infection Control Committee Approval:	04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/17
Professional Affairs Committee Approval:	07/17
Board of Directors Approval:	

A. **PURPOSE:**

1. The purpose of hand hygiene is to remove microorganisms and reduce the risk of transmitting disease and/or significant pathogens to patients, healthcare workers, environment, and visitors.

B. **GENERAL INFORMATION:**

1. Hand hygiene is the single most important activity for preventing transmission of infectious microorganisms.
2. Multiple studies have shown that the hands of healthcare workers carry large numbers of germs. Transient flora are acquired from patients or contaminated environmental surfaces and are more likely to cause healthcare-associated infections than resident flora – bacteria always found on the skin. Normal shedding of skin cells spreads germs that are carried on the skin.
3. **Length of nails/Fingernail polish/** Artificial ~~Finger~~nails:
   - **a. Fingernails must be less than ¼ inch in length, clean and trimmed.** Long natural nails carry twice the number of germs compared to short (less than ¼ inch) natural fingernails.
   - ~~a.~~**b. Fingernail polish is permitted as long as there is no chipping or peeling.** Freshly applied nail polish does not increase the number of bacteria but chipped nail polish may support the growth of larger numbers of organisms on fingernails.
   - ~~b.~~**c.** Pursuant to Center for Disease Control (CDC) guidelines **and the World Health Organization (WHO), all health care workers and providers**~~Tri-City Health District employees~~ who **provide**~~deliver~~ direct **"hands on"** patient care cannot wear artificial fingernails**, nail extenders/tips** ~~or~~ **or** nail jewelry. ~~and nails must be less than one fourth inch in length, clean and trimmed per Administrative Dress and Appearance Philosophy Policy #415.~~
4. Wearing gloves does not provide complete protection against microorganisms. Up to 30% of healthcare workers who wear gloves during patient contact will be carrying germs from the patient they just touched after the gloves are removed. Bacteria and viruses gain access to their hands through small holes in gloves and/or during glove removal.
   - ~~1. Adding soap to a partially empty soap container or "topping off" can lead to bacterial contamination of the soap.~~
5. ~~Three~~Indications for ~~handwashing~~**hand washing** and hand antisepsis:
   - a. Wash hands with hospital-approved soap and water when hands are visibly dirty or contaminated with blood or other potentially infectious material (all body fluids except sweat).
   - ~~a.~~**b.** If hands are not visibly soiled, **may** use an alcohol-based waterless antiseptic agent.

~~Standard Precautions include:~~

c. Perform hand hygiene before caring for patients

~~i.~~**d.** Perform hand hygiene after contact with any patient even for simple activities, such as taking a pulse or blood pressure, or lifting a patient.

~~ii.~~**e.** Perform hand hygiene after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings.~~, as long as hands are not visibly soiled.~~

~~2.~~**f.** Perform hand hygiene if moving from a contaminated body site to a clean body site during patient care.

~~3.~~**g.** Perform hand hygiene after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

~~4.~~**h.** ~~Perform hand hygiene before caring for patien~~**Perform hand hygiene**~~Decontaminate hands~~ before donning gloves when performing invasive procedures such as inserting a intravascular catheter, indwelling urinary catheter or naso-gastric tube.

~~5.~~**i.** **Perform hand hygiene**~~Decontaminate hands~~ after removing gloves.

C. **HAND HYGIENE TECHNIQUES:**

1. Waterless **B**~~b~~ased **P**~~p~~roducts:~~.~~

~~6.~~**a.** When decontaminating hands with a waterless alcohol-based hand rub, apply product to palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.

~~7.~~**b.** If an adequate volume of an alcohol-based hand rub is used, it should take 15 to 25 seconds for hands to dry. Follow the manufacturer's recommendations for the volume of product to use.

2. Soap and Water:

~~8.~~**a.** When washing hands with soap, wet hands first with warm water, apply 3 to 5 ml of detergent to hands and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet.

~~9. Surgical hand antisepsis - See Surgical Services Unit Specific Procedure #59 "Surgical Hand Asepsis" for details.~~

~~2.~~**3.** Gloves:

a. Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, and non-intact skin will occur.

b. Remove gloves after caring for a patient. Do not wear the same pair of gloves for the care of more than one patient, and do not wash gloves between patients.

c. Change gloves during patient care if moving from a contaminated body site to a clean body site.

d. Perform hand hygiene after glove removal.

4. Surgical Hand Antisepsis

a. **See Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis for details.**

D. **RELATED DOCUMENT(S):**

1. Dress and Appearance Philosophy Policy, Human Resources Policy #86401-415

2. Patient Care Services Policy: Surgical Services: Surgical Attire Policy

~~1.~~**3. Patient Care Services Policy: Surgical Services: Surgical Hand Asepsis**

E. **REFERENCES:**

1. Center for Disease Control and Prevention. Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. MMWR 2002;51(No.RR-16:1-45)

2. California OSHA, Title 8, Subchapter 7. General Industry Safety Orders, Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes, 5193. Bloodborne Pathogens. 1991, revised 1998.
3. US Dept. of Labor, OSHA Part 1910, Occupational Safety and Health Standards, -29 CFR Toxic and Hazardous Substances 1910.1030 Bloodborne Pathogens. 1991 rev. 1992, 1996 and 2001.
~~3.~~4. **WHO Guidelines on Hand Hygiene in Health Care 2009**

Tri-City Health Care District
Oceanside, California

Infection Control Policy ~~Manual~~

ISSUE DATE: 09/01

SUBJECT: **Management of Patients with HIV-Infection/AIDS**

REVISION DATE: 09/04, 04/17

STANDARD NUMBER: IC. 8

Department Approval:	**04/17**
Infection Control Committee Approval:	**~~10/13~~04/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **GENERAL INFORMATION:**

1. ~~General Information~~**Acquired Immunodeficiency Syndrome** (AIDS) is caused by a retrovirus, called Human Immune Deficiency Virus (HIV). Routine social or community contact with an HIV-infected person carries no risk of transmission. HIV is only contacted by sexual exposure and exposure to blood or tissues. For example:
   a. Unprotected sexual intercourse.
   b. Direct contact of your blood with an infected person's blood.
   c. Sharing of HIV contaminated needles and syringes.
   d. From mother to newborn, either during pregnancy or after birth.
   e. Breastfeeding by HIV-infected mothers.

B. **PROCEDURE:**

1. The isolation of the individuals for HIV-infection is unnecessary, ineffective and unjustified.
~~1.1.~~**2.** Standard precautions apply to all hospitalized patients and additional precautions (Airborne, Droplet, or Contact) may be appropriate for specific infections.
~~1.2.~~**3.** Place all HIV positive patients with pulmonary infiltrates in Airborne Precautions until three sputum smears are **Acid-Fast Bacilli** (AFB) negative or until a diagnosis other than tuberculosis is clearly established.
~~2.~~**4.** If HIV testing is ordered, follow the policy as outlined in **Lab** Administrative: **Authorization for Laboratory Testing** ~~Manual~~.
~~3.~~**5.** Healthcare workers with exposure to blood or other body fluids are to follow the **Patient Care Services** ~~Employee Health: Policy~~ **HIV Testing In an** Occupational Exposure **Policy** ~~to Blood/Body Fluids~~.

C. **RELATED DOCUMENTS**:

1. **Employee Health: ~~Bloodborne Pathogen Exposure: Guide to~~ HIV ~~Postexposure Prophylaxis (PEP): Employee Health & Wellness Manual~~ Guideline Grid**
2. **Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11 Policy**
3. Infection Control: Bloodborne Pathogen Exposure Control Plan **Policy**
~~1.~~**4. Patient Care Services: HIV Testing In an Occupational Exposure Policy**

D. **REFERENCES:**

1. California Healthcare Association. (~~2010~~**2017**) Consent Manual. California Healthcare Association, Sacramento, Ca.

2. Center for Disease Prevention and Control. (2001). June 29, 2001 / 50(RR11);1-42 Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HBV, HCV, and HIV
3. Centers for Disease Control and Prevention. (1996). Guideline for Isolation Precautions in Hospitals. American Journal of Infection Control, 24 (1), 24-4
4. **https://www.cdc.gov/hai/organisms/hiv/hiv.html**
5. **Human Immunodeficiency Virus (HIV) in Healthcare Settings**
~~3.~~**6.** Recommendations for the prevention of HIV transmission in health-care settings. MMWR, 36, 1S -18S.
7. **Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. Published: 9/25/2013 https://stacks.cdc.gov/view/cdc/20711**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 09/11

SUBJECT: Credentialing Criteria, Cardiac Rehab (Outpatient)

REVISION DATE(S): 09/11

POLICY NUMBER: 8710 – 564

Department Approval:	03/17
Credential Committee Approval:	~~09/11~~04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~09/11~~06/17
Professional Affairs Committee Approval:	07/17
Board of Directors Approval:	09/11

A. **PURPOSE:**

1. To provide criteria for use in credentialing physicians who request privileges in cardiac rehabilitation at the centers located at 4002 Vista Way, Oceanside and at 6250 El Camino Real, Carlsbad.

B. **INITIAL CREDENTIALING:**

1. Board certified by the American Board of Cardiology, American Board of Internal Medicine, American Board of Family Practice or the American Board of Emergency Medicine; or completion of an ACGME-approved residency in Cardiology, Internal Medicine, Family Medicine or Emergency Medicine;
2. For non-cardiologists, experience in cardiovascular care;
3. Current ACLS certificate or experience and knowledge in emergency procedures.

C. **PRIVILEGE AND PROCTORING REQUIREMENTS:**

PRIVILEGE	PROCTORING	REAPPOINTMENT
Consultation, cardiac rehab locations	2	10

D. **ONGOING PROFESSIONAL PRACTICE EVALUATION:**

1. Cases will be reviewed on an ongoing basis and reported to the practitioner's primary department/division with the goal of patient safety and successful performance of the procedure(s).

~~**Approvals:**~~
~~**Credentials Committee Approval: 09/11**~~
~~**Medical Executive Committee Approval: 09/11**~~
~~**Board of Directors Approval: 09/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 02/90

SUBJECT: Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds

REVISION DATE(S): 01/03, 03/09; 11/10; 01/11

POLICY NUMBER: 8710 – 522

Department Approval:	03/17
Department of Emergency Medicine Approval:	03/17
Credential Committee Approval:	~~03/11~~04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/17
Professional Affairs Committee Approval:	07/17
Board of Directors Approval:	

A. **PURPOSE:**

1. The purpose of this credentialing process **is**~~is intended for the following~~:
   a. To define the core privileges for ~~emergency~~ ultrasound in **E**~~e~~mergency **M**~~m~~edicine.
   b. To outline the two pathways by which **E**~~e~~mergency **P**~~p~~hysicians and **P**~~p~~hysician **A**~~a~~ssistants may demonstrate competency in basic emergency ultrasonography.

B. **CORE PRIVILEGES:**

1. Limited obstetrical ultrasonography, both transabdominal and endovaginal, to verify intra-uterine pregnancy.
2. Limited abdominal ultrasonography including limited renal, evaluation for abdominal aortic aneurysms, and Focused Abdominal Sonography ~~of~~ **for** Trauma (eFAST) to evaluate for evidence of free intraperitoneal fluid, pericardial fluid, and pneumothorax.
3. Procedural guidance for procedures **E**~~e~~mergency **P**~~p~~hysicians and **P**~~p~~hysician **A**~~a~~ssistants are credentialed to perform in a blinded manner, including but not limited to central line placement, paracentesis, **thoracentesis,** pericardiocentesis, and drainage of soft tissue fluid collections.

C. **CREDENTIALING PATHWAYS:**

1. In accordance with the 2007 Model of Clinical Practice of Emergency Medicine as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American College of Emergency Physicians (ACEP) policy statement for emergency ultrasound guidelines, two pathways are recognized to demonstrate proficiency in emergency ultrasound.
   a. Residency-based Pathway which requires demonstration of completion of an ACGME-approved Emergency Medicine residency program that includes training in emergency ultrasonography.
   b. Practice-based Pathway which requires both of the following:
      i. Completion of a formal course in basic emergency medicine ultrasound covering the core applications with both didactics and practical hands-on sessions.
      ii. Experiential training period during which the practitioner must perform a minimum of 25 cases in **each of** ~~each of the 1-2 listed~~ core privileges **#1 and #2 above**.
         1) During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.
         2) The proctoring shall be conducted by emergency physicians already credentialed in basic emergency medicine ultrasonography.
      iii. Core privilege number 3, procedural guidance privileges, **has** no proctoring

requirement ~~ed~~ if **the** practitioner is already credentialed to do **the** procedure in a blinded fashion.

D. **REFERENCE(S):**

1. American College of Emergency Physicians 2008 Ultrasound Credentialing Guidelines
2. Core Privileges for Physicians, Fourth Edition, 188-195.
3. ACGME 2007 Model of Clinical Practice of Emergency Medicine
4. American Medical Association House of Delegates Resolution 802 and policy 230.989.

~~**Approvals:**~~

~~**Emergency Medicine Department Approval:**~~	~~**01/11**~~
~~**Credentials Committee**~~	~~**03/11**~~
~~**Medical Executive Committee Approval:**~~	~~**03/11**~~
~~**Board of Directors Approval:**~~	~~**10/05; 05/09; 03/11**~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 07/01	**SUBJECT:** **Criteria for Granting Moderate and Deep Sedation/Analgesia Privileges to Non-Anesthesiologists**
REVISION DATE(S): 12/07, 05/09, 02/10, 11/12	**POLICY NUMBER: 8710 – 517**

Department Approval Date:	**~~09/12~~02/17**
Department of Anesthesiology Approval Date:	**03/17**
Credential Committee Approval Date:	**04/17**
Pharmacy and Therapeutics Approval Date:	**n/a**
Medical Executive Committee Approval Date:	**~~10/12~~06/17**
Professional Affairs Committee Approval Date:	**07/17**
Board of Directors Approval Date:	**11/12**

A. **APPLICABILITY:**

1. This policy applies to the use of sedation and analgesia in all hospital departments and areas except as stated below:
   a. This policy does not apply to patients who have an anesthesiologist providing sedation because anesthesiologists are governed by the standards of care established by the Department of Anesthesiology. This policy does not apply to patients who are mechanically ventilated and whose cardiovascular and respiratory status are continuously monitored by the same monitoring devices as specified per the Patient Care Services procedure "Deep Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures and documented according to protocol. This policy does not cover patients who receive anxiolytic or analgesic agents, which are administered routinely to alleviate pain and agitation (e.g., sedation for treatment of insomnia, post-operative analgesia).

B. **DEFINITION OF SEDATION:**

1. Monitored Anesthesia Care (MAC): Anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia. Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.

~~1.~~**2.** Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

~~2.~~**3.** Moderate Sedation/Analgesia: **("Conscious Sedation")** A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

~~3.~~**4.** Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

~~4.~~**5.** Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified

practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

C. **PRIVILEGES:**

1. Privileges for Moderate and Deep Sedation will be granted pursuant to this policy. The non-anesthesiologist physician administering the Deep Sedation must be different from the individual performing the diagnostic or therapeutic procedure.
2. Privileges for Minimal Sedation are part and parcel of individual departmental privileges, and anesthesia privileges are granted within the Anesthesiology Department only.

D. **REQUIREMENTS FOR MODERATE SEDATION PRIVILEGES**:

1. Initial applicant competency shall be demonstrated by:
   a. Successful completion of an ACGME/AOA accredited residency in a relevant medical specialty or Licensed by the Physician Assistant Committee of the Medical Board of California.
   b. Procedural sedation must be part of core content of specialty.
   c. Pass Moderate Sedation Credentialing Examination with a grade of 80% or better.
   d. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Moderate Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures."
2. Proctoring: Two (2) moderate sedation cases proctored by a Medical Staff member with unsupervised moderate sedation privileges or an anesthesiologist.
3. Reappointment:
   a. Pass moderate sedation credentialing examination with a grade of 80% or better.
   b. Demonstrate competency by documented completion of three (3) cases of moderate sedation every two (2) years with no significant issues resulting in inability to rescue patient as identified by quality improvement activities/peer review mechanism established by the Medical Staff.
   c. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Moderate Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures".

E. **REQUIREMENTS FOR DEEP SEDATION PRIVILEGES (Effective for privileges initially appointed or reappointed effective upon 9/2012 approval of policy):**

1. Initial applicant competency shall be demonstrated by:
   a. One of the following:
      i. Recent (within two years) completion of an ACGME residency or fellowship training with documented inclusion of deep sedation; OR
      ii. Recent (within six months) completion of an ACCME-approved (or equivalent for dental, oral surgical and podiatric continuing education) deep sedation educational program, which includes the safe administration of sedative and analgesic drugs used to establish a level of deep sedation, and rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation, and subject areas as recommended by the American Society of Anesthesiologists; OR
      iii. Board certified/board eligible in Emergency Medicine and documentation of twenty (20) cases of deep sedation/airway management/intubation in the previous two years.
   b. Completion of a Deep Sedation exam with score of 80%
   c. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Deep Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures."
   d. Current unrestricted DEA registration including schedules II-IV.
   e. Current ACLS certification (Emergency Medicine Department physicians exempt).
2. Proctoring: For initial appointees pursuant to (i) and (iii) immediately above, two (2) cases

proctored by a Medical Staff member with unsupervised Deep Sedation privileges or an anesthesiologist. For initial appointees pursuant to (ii) immediately above, ten (10) days~~es~~ proctored by a Medical Staff member with unsupervised Deep Sedation privileges or an anesthesiologist.

3. Reappointment:
   a. Continuing medical education in the delivery of anesthesia service.
   b. Completion of Deep Sedation Exam with a score of 80% or better.
   c. Demonstrate competency by documented completion of three (3) deep sedation/airway management/intubation cases every two (2) years with no significant issues. If the required number of cases is not performed, the physician will be required to undergo proctoring.
   d. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Deep Sedation/Analgesia Using during Therapeutic or Diagnostic Procedures."
4. Note: Deep sedation privileges for Emergency Medicine physicians meeting the above criteria includes the treatment of pediatric patients.

F. REFERENCES~~Resources:~~

~~F.~~1. Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners, ASA, October 20, 2010

~~**Approvals:**~~

~~**Anesthesiology Department Approval: 09/12**~~
~~**Medical Executive Committee Approval: 10/12**~~
~~**Board of Directors Approval: 12/07; 05/09; 02/10; 11/12**~~

Tri-City Health Care District
Oceanside, California

Tracked Changes

~~Medical Staff~~Women and Newborn Services ~~Policy Manual~~

ISSUE DATE: **~~09/09, 12/15~~02/10**

SUBJECT: **Neonatal ~~Narcotic Withdrawal~~Abstinence Syndrome, Pharmacological Treatment of**

REVISION DATE(S):

POLICY NUMBER: **8710-559**

Medical Staff Department Approval:	**01/17**
Perinatal Collaborative Practice:	**04/17**
Department of Pediatrics Approval:	**~~01/10~~05/17**
Pharmacy and Therapeutics Approval:	**05/17**
Medical Executive Committee Approval:	**~~02/10~~06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**02/10**

A. **PURPOSE:**

1. **To stabilize clinical manifestations of neonatal withdrawal and restore normal newborn activity.** ~~To treat infants of known in utero exposure to opiate narcotics.~~

B. **PROCEDURE:**

~~1. The infant shall be evaluated in the newborn nursery by the pediatrician according to hospital policy.~~

~~2. Mothers on a methadone program may breastfeed if they wish.~~

1. Neonatal Abstinence ~~Scores~~ **Syndrome** (NAS) shall be ~~measured~~ **monitored per WNS policy "Management of Neonatal Abstinence Syndrome."** ~~every 3 to 4 hours prior to~~ **after** ~~feeds using the Finnegan scoring system.~~

~~3. If there are two consecutive scores greater than 8~~ **~~or one greater than 12~~**, ~~the pediatrician shall be notified.~~

   a. ~~Recommend transferring the infant to NICU for pharmacologic therapy.~~

2. The **following** recommended pharmacologic agents **may be used solely or in combination:** ~~are:~~

   ~~b. Phenobarbital 3- 4 mg/kg/day PO given in two divided doses as a maintenance dose and~~

   a. Morphine 0.05 **-0.**1 mg/kg/dose **IV if NPO, or** PO every 3 **hours.** ~~to 4 hours with feeding~~**Recommended~~s.~~ maximum dose is 0.2mg/kg/dose.**

      ~~i. This morphine dose shall be maintained for 48 hours provided NAS scores remain less than 8.~~

      i. For NAS scores greater than 8 ~~on this regimen~~, increase the morphine dose in increments of 10% until the score is below 8. The infant shall be maintained on the morphine dose that controls symptoms for 48 hours.

      ii. If the infant is excessively sleepy or unable to feed on this morphine dose, decrease the dose in increments of 10% until the infant is stable, awake and scores less than 8.

      iii. **This morphine dose shall be maintained for 48 hours provided NAS scores remain less than 8 prior to weaning.**

      ~~ii.~~ Once stable on the same morphine dose for 48 hours, the infant may start to wean from the morphine. The dose should be weaned by 10% **to 20%** of the ~~current~~**original** dose ~~every 24 to 48 hours~~**daily** providing scores remain less than **or equal to** 8.

~~iii. For any two scores greater than 8 in a 24-hour period, do not wean the infant for an additional 24 hours.~~

~~iv. For any single score in a 24-hour period greater than 12, increase the morphine dose by 10% and hold for 24-48 hours.~~

iv. **Once the infant has reached a morphine dose of 0.1mg or less (total dose amount, NOT mg/kg) every 3 hours, the recommended tapering schedule is as follows:**

1) Guided by Finnegan Scores of less than or equal to 8, w~~W~~ean frequency every 24-48 hours ~~daily~~ to q4hrs, q6hrs, q8hrs, q12hrs, q24 hrs, and then discontinue.

~~Taper dose every 24-48 hours as tolerated, guided by Finnegan Scores of less than or equal to 8~~

~~v. When the infant reaches ½ of the initial starting morphine dose, hold morphine for scores less than 6~~

~~vi. While on a scheduled morphine, o~~**~~O~~**~~ral sucrose is to be used~~ **~~for painful procedures only.~~** ~~minimally for comfort care.~~

~~vii. Do not use oral sucrose when morphine dosing is on hold or PRN as this could mask further withdrawal symptoms and prolong the hospitalization.~~

~~For infants who have reached half of their initial morphine dose and consistently have scores greater than 6 but less than 8, weaning may be initiated to keep scores less than 8. Physician to determine change to weaning after review of clinical case.~~

v. Observe infant off morphine for 48-72 hours prior to discharge.

b. **If Finnegan scores are not stabilized on Morphine, consider starting an adjunct therapy of either:**

i. Phenobarbital:

1) Loading dose: 16mg/kg PO on day 1

2) Maintenance: ~~2~~ 1 to 4 mg/kg/dose ~~/day~~ PO every 12 hours

3) Once stable for 48 hours (scores less 8), wean dose by 20% every other day, alternating with morphine weaning schedule. ~~.~~

ii. Clonidine:

1) ~~-~~0.5-1 mcg/kg PO every 4-6 hours.

2) Only to be used for infants 35 weeks gestation or greater.

3) Clonidine must be tapered off over 10-14 days and can be monitored in the outpatient setting.

~~viii.~~**iii.** ~~When the infant does not require any doses of morphine for 2 days, discharge shall be considered. Further observation may be needed at the discretion of the physician for clinical considerations.~~ Infant may be discharged home on phenobarbital **and/or clonidine if unable to effectively wean to off.**

~~i. only.Phenobarbital can usually be weaned off by decreasing the dose 10 - 20% per week as an outpatient; however, clinical conditions may dictate other dosing adjustments.~~

~~ii. Clonidine must be tapered off over 10-14 days and can be monitored in the outpatient setting.~~

~~REFERENCES:~~

~~**Agthe AG et al. Clonidine as an Adjunct Therapy to Opioids for Neonatal Abstinence Syndrome: A Randomized, Controlled Trial. Pediatrics 2009; 123:e849-e856.**~~

~~**American Academy of Pediatrics Committee on Drugs (2012). Neonatal Drug Withdrawal. Pediatrics 2012; 129; e540.**~~

~~**Bio LL, Siu A, and Poon CY. Update on the pharmacologic management of neonatal abstinence syndrome. Journal of Perinatology (2011) 31, 692-701.**~~

~~**Neofax. 2017. Truven Health Analytics Inc.**~~

~~**Approvals:**~~
~~**Pharmacy & Therapeutics Approval:**~~
~~**Division of Neonatology Approval: 01/10**~~
~~**Medical Executive Committee Approval: 02/10**~~
~~**Board of Directors Approval: 02/10**~~

Tri-City Health Care District
Oceanside, California

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Women and Newborn Services

ISSUE DATE: 02/10

SUBJECT: Neonatal Abstinence Syndrome, Pharmacological Treatment of

REVISION DATE(S):

POLICY NUMBER: 8710-559

Medical Staff Department Approval:	**01/17**
Perinatal Collaborative Practice:	**04/17**
Department of Pediatrics Approval:	**05/17**
Pharmacy and Therapeutics Approval:	**05/17**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**02/10**

A. **PURPOSE:**

1. To stabilize clinical manifestations of neonatal withdrawal and restore normal newborn activity.

B. **PROCEDURE:**

1. Neonatal Abstinence Syndrome (NAS) shall be monitored per WNS policy "Management of Neonatal Abstinence Syndrome."
2. The following recommended pharmacologic agents may be used solely or in combination:
   a. Morphine 0.05 -0.1 mg/kg/dose IV if NPO, or PO every 3 hours. Recommended maximum dose is 0.2mg/kg/dose.
      i. For NAS scores greater than 8, increase the morphine dose in increments of 10% until the score is below 8. The infant shall be maintained on the morphine dose that controls symptoms for 48 hours.
      ii. If the infant is excessively sleepy or unable to feed on this morphine dose, decrease the dose in increments of 10% until the infant is stable, awake and scores less than 8.
      iii. This morphine dose shall be maintained for 48 hours provided NAS scores remain less than 8 prior to weaning.
      iv. Once stable on the same morphine dose for 48 hours, the infant may start to wean from the morphine. The dose should be weaned by 10% to 20% of the original dose daily providing scores remain less than or equal to 8. Once the infant has reached a morphine dose of 0.1mg or less (total dose amount, NOT mg/kg) every 3 hours, the recommended tapering schedule is as follows:
         1) Guided by Finnegan Scores of less than or equal to 8, wean frequency every 24-48 hours to q4hrs, q6hrs, q8hrs, q12hrs, q24hrs, and then discontinue.
      v. Observe infant off morphine for 48-72 hours prior to discharge.
   b. If Finnegan scores are not stabilized on Morphine, consider starting an adjunct therapy of either:
      i. Phenobarbital:
         1) Loading dose: 16mg/kg PO on day 1
         2) Maintenance: 1 to 4 mg/kg/dose PO every 12 hours
         3) Once stable for 48 hours (scores less 8), wean dose by 20% every other day, alternating with morphine weaning schedule.
      ii. Clonidine:

1) 0.5-1 mcg/kg PO every 4-6 hours.
2) Only to be used for infants 35 weeks gestation or greater.
3) Clonidine must be tapered off over 10-14 days and can be monitored in the outpatient setting.

iii. Infant may be discharged home on phenobarbital and/or clonidine if unable to effectively wean to off.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE:	**01/07**	**SUBJECT:**	**Peer Review Process: OPPE and FPPE**
REVISION DATE:	**03/08, 05/08, 06/08, 07/15**	**POLICY NUMBER:**	**8710 – 509**

Department Approval:	**~~03/17~~06/17**
Medical Staff Committee Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/17~~06/17**
Professional Affairs Committee Approval Date:	**~~04/17~~07/17**
Board of Directors Approval:	**04/17**

A. **POLICY:**

1. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.

B. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. Ongoing Evaluation: At eight (8) month intervals, every Practitioner will undergo ongoing evaluations defined by each Department/Division. Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists that requires a focused evaluation; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:
    i. Patient Care
    ii. Medical / Clinical Knowledge
    iii. Practice-based learning and Improvement
    iv. Interpersonal and communication skills
    v. Professionalism
    vi. Systems / Based Practice
2. Routine Individual Case Review is initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii) performance varying significantly from other organizations; (iii) performance varying significantly from

recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

a. Initial Review: will be performed by the applicable department, division or committee (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical ~~QA/PI~~**Quality/Peer Review** Committee **(MQPR)**.

b. Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the **MQPR and** Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

c. Reporting Findings: The findings of peer review activities are reported through the department/division/quality review committee to the ~~QA/PI/PS~~**MQPR** Committee and on to the Medical Executive Committee within forty-five (45) days of completion.

d. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

C. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

1. FPPE includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are not limited to, provision of inappropriate care, including a single egregious incident or a clinical

practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the **MQPR Committee and** MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.

b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring

c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing within five business days. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.

D. **GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:**

1. Participants in the Peer Review Process:

a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.

b. Reviewer(s): The Department/Division/Committee Chair/Chief shall appoint Practitioners to perform case screening. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.

c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.

d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.

e. Data Sources/Collection: The cases for peer review are derived from quality review ~~form~~**reports**, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.

f. Criteria shall be reviewed by each department/committee/ annually. The criteria can be changed before the annual review with request from Department Chair.

g. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.

h. Incomplete case reviews are referred to the next scheduled meeting.

i. Cases referred for review shall be reviewed by the Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.

j. Cases referred for discussion shall be summarized in sufficient detail to ascertain the salient facts of the case, the issue under discussion, and the reasoning underlying the committee(s) decision.

k. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

l. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of ~~Quality Assurance/Performance Improvement/Patient Safety Committee~~**MQPR Committee** and may require direct intervention.

~~l.~~**m.** For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

E. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         a. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         a. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         a. These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      iv. Violation of Hospital Policy Includes poor communication or inadequate documentation.
      v. Violation of Physician Code of Conduct These behavioral events will initiate an immediate response. The physician will be notified.

F. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the ~~Medical Executive~~**MQPR** Committee shall serve as the ~~final appeal body~~ **appeal review body and the MEC as the final appeal body**.
3. The Medical Staff member may review his/her file on request **as outlined in the Medical Staff Bylaws**.

4. ~~Quality Assurance/Performance Improvement/Patient Safety Committee~~**MQPR Committee** oversees and supervises all medical staff peer review activity. When a subsidiary peer review body is not performing appropriately, the ~~Quality Assurance/Performance Improvement/Patient Safety Committee~~**MQPR Committee** is responsible for resolving issues.
5. When the ~~Quality Assurance/Performance Improvement/Patient Safety Committee~~**MQPR Committee** disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.
6. Any evaluation of a quality event that is not completed within six (6) months of initial review will be ~~assessed by the Chairman of the Quality Assurance/Performance Improvement/Patient Safety Committee~~**reported to the MQPR Committee and may be subject to assessment by the committee chairperson**.

G. **REFERENCES:**

1. Medical Staff Standards, Joint Commission 2017
2. Effective Peer Review A Practical Guide to Contemporary Design, ~~2~~**3**rd Edition, Robert Marder, May ~~2008~~**2013**

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 06/02	**SUBJECT:** Supervision of Residents in Emergency Medicine
REVISION DATE: 06/02; 02/06, 04/08; 10/13	**POLICY NUMBER:** 8710 – 571

Medical Division Approval:	**~~04/16~~02/17**
Department of Emergency Medicine:	**05/17**
Medical Executive Committee Approval:	**~~04/16~~06/17**
Professional Affairs Committee Approval:	**~~05/16~~07/17**
Board of Directors Approval:	**05/16**

A. **POLICY:**

1. All medical care provided by Emergency Medicine (EM) Residents is under the supervision of the Director of the Emergency Residency Rotation or a designated Medical Staff member(s) who are member (s) of **Tri-City Healthcare District (**TC**HD**~~MC~~**)** Medical Staff. Each emergency medicine resident is at least a 3rd or 4th year emergency medicine resident who is doing a clinical rotation at TC**HD**~~MC~~ to round out their community hospital education. Every patient seen by an emergency medicine resident, on either required or elective clinical rotation, will have a designated emergency medicine physician medical staff member (s) who will be responsible for and will supervise all medical care provided by the residents, and will be directly involved in the treatment of every patient. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements, and potential participation in departmental grand rounds before starting his/her month long rotation. The residency rotation director gives individual verbal feedback of the residents' performance during the course of the rotation, in addition to submitting a formal written evaluation to the Emergency Medicine Residency Program Director at the completion of each resident's rotation (see sample Resident evaluation form). Finally, the progress of the program is reviewed at the GME committee annually, and on a**n ad hoc** ~~monthly~~ basis in the Emergency Department meeting.

B. **PROCEDURE:**

1. Orientation:
   a. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements (P&P 8710-513), and potential participation in departmental grand rounds before starting his/her month long rotation.
2. Orders:
   a. Emergency medicine residents may write orders on the chart, or type in orders utilizing the computer ordering system, ~~after discussing such orders with, and~~ under ~~direct~~ supervision and review by an attending emergency department physician - a member of the ~~TCMC~~ **TCHD** medical staff and the department of Emergency Medicine.
   b. Verbal orders are permitted during codes and extreme emergency situations with instantaneous review from the supervising emergency physicians present with the resident and patient.
      i. If a nurse or other hospital employee has any question about any order given by the emergency medicine resident they may immediately question the resident and the supervising emergency department physician.
   c. The supervising emergency department physician will review all orders.
3. Documentation:
   a. Documentation on each patient will be dictated by the emergency medicine resident

(complete dictation), or entered into the computerized documentation system. The attending emergency department physician will also document an attending summary either via dictation or using the computerized documentation system. (See P&P 8710-513).

4. Direct versus Indirect Supervision of Residents In the Emergency Department In accordance with the Common Program Requirements established by the Accreditation Council for Graduate Medical Education (ACGME), this section defines the levels of supervision provided to residents rotating through the emergency department at ~~Tri-City Medical Center~~**TCHD** for different stages of their training and for various labels of knowledge and skills.
   a. Levels of Supervision
      i. Direct Supervision: The supervising physician is physically present with the resident and the patient.
      ii. Indirect Supervision with Direct Supervision immediately available: The supervising physician is physically within the hospital and usually, within the department, and is immediately available to provide direct supervision.
   b. Permissible Level of supervision by graduate year of training
      i. Emergency medicine residents in Post Graduate Year 1 and 2 must be directly supervised at all times.
      ii. Emergency medicine residents in Post Graduate Year 3 and 4 may be indirectly supervised with direct supervision immediately available.
   c. While it is expected that the sequential levels of supervision allow for progressive independence and autonomy, residents rotating through ~~Tri-City~~**TCHD** emergency department may not supervise less experience residents but instead must be supervised only by an attending physician who is board certified (or board eligible) in emergency medicine.
5. Emergency Resident Position Description (job description) during ~~TCMC~~ **TCHD** rotation:
   a. Goals and objectives of the EM residency training program are set forth in the EM residency curriculum document. Overall, the goal of the EM training program is to provide EM residents with an extensive experience in the art and science of emergency medicine in order to achieve excellence in the diagnosis, care and treatment of emergency patients-Additionally, this experience will help to establish the trainee's eligibility to participate in the American Board of Emergency Medicine's board examination. In accordance with this curriculum, the EM resident trainee agrees to do the following while at ~~TCMC~~**TCHD**, other institutions and the parent organization:
      i. Develop and participate in a personal program of self-study and professional growth with guidance from the EM faculty teaching staff.
      ii. Under the supervision of the EM faculty, participate in safe, effective, and compassionate patient care, consistent with the trainee's level of education and experience and in accordance with the Residency's description of graduated responsibility.
      iii. Participate fully in the educational activities of the residency program and assume responsibility for participation in the teaching of more junior physicians, of medical students and students in allied health professions.
   b. The required educational activities of the EM residency are summarized as follows:
      i. A minimum attendance level at all mandatory EM conferences either offsite or onsite.
      ~~ii. Complete assigned core curriculum lecture presentations (1 or 2 minimum during residency training period) in a timely fashion with guidance from the EM faculty.~~
      ~~iii.~~**ii.** Record and update procedure logs, ultrasound logs, and patient follow up logs. Participate in procedure labs and follow up conference. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
      ~~iv. Participate in the standing committees of the Medical Staff and institutional~~

~~committees, as assigned by the program director, especially those that relate to patient care review activities.~~

~~v.~~**iii.** Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and the practice of emergency medicine. Learn cost containment measures in the provision of patient care.

~~vi.~~**iv.** Perform all duties in accordance with the established practices, procedures and policies of the institution, the emergency medicine program, and other institutions to which the resident is assigned.

~~vii.~~**v.** Formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed.

~~viii.~~**vi.** The EM-3 resident will have developed skills as a clinical teacher and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.

~~ix.~~**vii.** Adhere to the emergency department schedule of assigned shifts, as well as the call schedule and assignments of off service rotations, in a prompt and timely fashion.

c. Document patient care in the medical record in a timely fashion as per medical staff policy.

i. Adhere to the ACGME institutional requirements and the ACGME-RRC program requirements for emergency medicine.

ii. Participate in the evaluation of the EM training program.

iii. Comply with the licensure requirements of the State of California and/or State of California requirements if in Active Duty, and the laws of the State and Federal Governments.

iv. Adhere to the policies of the Emergency Medicine Residency- parent and rotation and adhere document entitled; Guidelines for Managing Impaired Residents.

v. Adhere to the principles of the SAEM and CORD Statement on Professionalism in Emergency Medicine summarized as follows:

1) The specialty of emergency medicine recognizes the importance of defining its professional responsibilities, values, and commitments. Trainees must be taught and emergency physicians must practice the following:

a) To make clinical decisions according to the best interests of the patient.

b) To behave in a manner that enhances patient trust.

c) To deliver high quality emergency medical care, maintaining the highest level of knowledge and skills.

d) To listen attentively, maintain confidentiality, and communicate truthfully, respectfully, openly, and honestly.

e) To be an advocate for the health care needs of emergency patients and the community.

f) To place the interest and well-being of the patient above self-interest.

g) To serve as a role model for health care professionals in training.

h) To work collegially with others, helping to create a productive and effective work environment.

d. Summary:

i. Professionalism is defined as behaviors that enhance the trust of patients and of society. This is accomplished by putting the needs of patients ahead of the physician's self-interest. Professionalism must be demonstrated by all emergency medicine professionals, integrated into residency training programs, and continually reinforced. At this time of tumultuous change, professionalism serves as a point of reference, at the core of the identity of the emergency medicine specialist.

C. **GRADUATED RESPONSIBILITY FOR EMERGENCY MEDICINE RESIDENTS:**

1. The emergency medicine (EM) residency provides a graduated level of responsibility for EM trainees. Residents enter into the EM residency after successful completion of a PG-I (general internship) and in the case of the Navy residents some in the field practice. These residents are assumed to have developed the basic skills of history-taking and physical examination, as well as general medical and surgical patient work-up and management
2. Before the emergency medicine resident arrives at ~~TCMC~~**TCHD**, he/she will be expected to have mastered basic skills in initial stabilization, essential diagnostic work-up, emergency core procedures, and emergency department management of individual acutely ill and injured patients in the unique environment of the ED.
3. By completion of the EM-2 (PGY-III) year, EM residents will have acquired expertise in multi-tasking and managing both patient care and administrative responsibilities simultaneously. The EM-2 resident will be comfortable in managing, and prioritizing the patient care of multiple patients. Furthermore, EM-2 residents will be able to take on the additional responsibilities of the stabilization and work-up of emergency department patients, emergency core procedures, and coordinating further inpatient or outpatient evaluation and care with representatives of other specialties. Furthermore, EM-2 residents will actively participate as base hospital physicians directing paramedic pre-hospital providers.
4. Upon completion of the EM-3 (PGY-IV) year of residency, EM trainees will have mastered all the above skills and in addition be capable of supervising all operational issues regarding patient flow and prioritization in the ED, as well as the pre-hospital setting. An EM faculty member is continuously present in the ED, but the EM-3 resident is expected to formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed. The EM-3 resident will have developed skills as a clinical teacher, and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.
5. Residency progress will be reviewed; problems with communication, suggestions for improvement, and other questions of a general nature will be addressed. Any specific medical problem with the resident's management will be discussed in the monthly Department QA meetings as necessary.

D. **RELATED DOCUMENT(S):**

1. ~~Sample~~ Resident Evaluation Form – **Sample**

Tri-City Medical Center
Medical Staff Office
4002 Vista Way
Oceanside, CA 92056
(760) 940-3071 (phone) * (760) 940-3486 (fax) plantsm@tcmc.com (e-mail) *

ANNUAL ASSESSMENT "EFFECTIVENESS OF GENERAL MEDICAL EDUCATION PROGRAM"

The Medical Executive Committee is interested in your comments regarding the GME program held at TCMC. Your feedback is vital to the continued success of the program.

ANNUAL ASSESSMENT "Effectiveness of GME Program"	Yes	No
1. Do you feel that the GME Program meets your needs? **Comments:**		
2. Have the medical students/residents/fellows been well received by the patients and staff? **Comments:**		
3. Are the medical students/resident's/fellows rotations sufficient to enable them to experience all acuity levels of the patients? **Comments:**		
4. Has the supervision of the medical students/residents/fellows been consistent with the standards? **Comments:**		
5. Was this program successful in meeting the needs of the hospital, patients and participants, and should the program be continued? **Comments:**		
6. During peer review, have there been any identified outliers that have not been consistent with the standard of care within the department? **Comments:**		
7. Has the clinical decision making process been appropriate and dependable? **Comments:**		
8. Were all safety precautions/protocols identified/followed? **Comments:**		
9. **Any additional comments/suggestions:**		
10. **Future Goals and Actions for 2017:**		

Thank-you for participating in the evaluation of TCMC's GME Program.

Signature *Date*

Please return completed form to the Medical Staff Office: Attn: Sarah Plant

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**FORMULA, PREPARATION AND STORAGE OF**
Purpose:	Powered specialty formula **and** fortification of formula ~~and breast milk~~ will be prepared in the NICU in an aseptic manner to assure sterility.
Supportive Data:	
Equipment:	1. Sterile Container 2. Disinfecting Wipes for Cleaning 3. **Non-Sterile** Gloves 4. Patient Identification Label **5.** Powdered Specialty Formula **~~5.~~6. Single-Use Scoop**

A. **POLICY:**

1. ~~Formula (artificial milk) will be available for supplementary use for infant feedings.~~ Breast milk is recognized as the feeding of choice for most infants, however, when breast milk is not available for use, or its use is contraindicated due to infant and/or maternal condition, or mother chooses to use formula, formula (artificial milk) will be available per physician/**allied health professional (AHP)** order~~.~~ **for supplementary use for infant feedings.**
2. Formula preparation and fortification are the responsibility of the Registered Nurse in the NICU. Caloric density and type of formula must be verified with the physician/**AHP** order prior to preparation.
3. The preparation of formula will be carried out in a designated area **away from the bedside** to decrease the risk of contamination.

B. **PROCEDURE:**

1. Verify physician/AHP's order for formula.
~~1.~~2. Perform hand hygiene and ~~G~~gather necessary equipment and supplies in designated formula preparation area.
~~2.~~3. Sanitize work surface, perform hand hygiene, and put on **non-sterile** gloves.
~~3.~~4. Measure formula into sterile container to desired volume.
~~4.~~5. Add powdered/liquid specialty formula into container with formula as per physician/**AHP**'s orders:
   a. Use single-use scoop **only**.
   b. Transfer appropriate number **of** scoops required for caloric density to sterile container
   c. Cap and shake vigorously to mix.
   ~~c.~~d. Label container appropriately with contents.
~~5.~~6. Fortified/mixed formula should be prepared fresh for each feed.
~~6.~~7. Refer to manufacturer guidelines for storage of unused formula.
~~7.~~8. Clean area after completion, wiping surface down with antiseptic wipes.

C. **REFERENCE(S):**

1. American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (201~~2~~02). Guidelines for Perinatal Care, **7th~~5th~~** ed.
2. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.

NICU Department Review	Perinatal Collaborative Practice	Division of Neonatology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
06/14, 05/17	06/14, 06/17	~~06/14~~n/a	~~07/14~~n/a	08/14, 07/17	08/14

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Appointment of Representative Form**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide a mechanism for appealing a claim denial on behalf of the patient who received services in the **Outpatient** Behavioral Health ~~Outpatient~~ Services **(OPBHS).**

B. **POLICY:**

1. The ~~Behavioral Health Outpatient Services~~ **OPBHS** staff will routinely explain and request the patient's signature on the Appointment of Representation Form (~~HCFA-1696-U4~~) on the patient's admission day. This form authorizes the Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** to represent the patient in a Medicare Appeal process in the event of denial of services~~. A member of the staff will also sign as an authorized official of the Tri-City Medical Center in the signature space provided.~~ Patients will be admitted regardless of their willingness to execute this form; it is not a condition of admission.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS clinical or administrative staff
   a. The **OPBHS**~~Behavioral Health Outpatient Services~~ will maintain an adequate supply of Appointment of Representative Forms.~~ (Attachment "A")~~
   b. On the day of admission to **OPBHS**~~Behavioral Health Outpatient Services~~, the staff responsible for completion of the admission paperwork will accurately complete the Appointment of Representation Form.
      i. Name (Claimant) (Print or type)
      ii. Social Security Number
      iii. Wage Earner (If Different)
      iv. Signature (Claimant)
      v. Address
      vi. Telephone Number (with Area Code)
      vii. Date
2. At this time the staff member will explain the rationale for this form to the patient, assure that the patient understands the content of the form and request the patient to execute (sign) the form in the appropriate signature space. The patient's consent will be voluntary and not required as a condition of admission. Do not sign as the "authorized official." This will be signed by the Medical Director or person responsible for all appeals.
3. The designated copy of the Appointment of Representative Form will be filed with appeals submitted to the Fiscal Intermediary.

D. **FORM(S):**

~~4.~~**1. Appointment of Representation Form (HCFA-1696-U4)**

Appointment of Representation Form (HCFA-1696-U4)

Social Security Administration
Please read the instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number
Wage Earner (If Different)	Social Security Number

Part I CLAIMANT'S APPOINTMENT OF REPRESENTATIVE

I appoint this individual, _____
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare) ☐ Title VIII (SVB)

This individual may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My principal representative is:

_____
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part II REPRESENTATIVE'S ACCEPTANCE OF APPOINTMENT

I, _____, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code)	Fax Number (with Area Code)	Date

Part III FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **I am charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **I am waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party entity or government agency, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **I am waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631 (d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Form SSA-1696-U4 (07-2014) ef (07-2014)
Use Prior Editions Until Exhausted

FILE COPY

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Daily Schedule

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	07/17
Board of Directors Approval:	

A. **PURPOSE**
1. To organize and outline the various groups and activities offered in Outpatient Behavioral Health Services **(OPBHS)** and assist patients in achieving their treatment goals.

B. **POLICY**
1. All groups and activities are arranged to therapeutically meet the needs of the patients.

C. **PROCEDURE**
1. Who may perform/responsible: Operations Manager, Clinical Coordinator or designee and Clinical Staff
~~1.~~2. The group schedule is posted throughout the **OPBHS**~~Program~~ and is given to each patient.
~~2.~~3. The schedule is revised as needed to meet the patient's individual needs.
~~3.~~4. Any change within the daily schedule is announced during the Community Meeting.
~~4.~~5. Therapists are to speak to each of their patients individually when there is a change in the patient's schedule.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Department Safety**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide general guidelines for maintaining a safe environment.

B. **POLICY:**

1. All program staff are responsible for the maintenance of a safe environment for patients, staff and visitors.

C. **PROCEDURE**

1. Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) Staff.

~~1.~~**2.** Program grounds are maintained in a manner that is designed to provide safe access to and a safe environment for patients, staff and visitors.

~~2.~~**3.** Emergency services are readily identifiable and easily accessible. Evacuation plans are posted throughout the facility.

~~3.~~**4.** Policies pertaining to safety issues are reviewed during orientation and annually with the program staff.

~~4.~~**5.** Any flammable, poisonous, sharp or potentially dangerous items are stored in a locked cabinet.

~~5.~~**6.** The nurse's station is closed when it is left unattended.

~~6.~~**7.** All exterior doors are to remain unlocked during program hours.

~~7.~~**8.** All corridors are to remain clear of furniture and equipment.

~~8.~~**9.** All building contents, including furniture, appliances and program materials must be kept in good ~~repair~~**condition**.

~~9.~~**10.** All safety hazards are reported to the Operations Manager and are documented on an incident report if appropriate.

~~10.~~**11.** The Operations Manager or designee, is responsible for the regular monthly visual safety inspection of the ~~Program~~**OPBHS.**

~~11.~~**12.** The Operations Manager, Safety Representative, or designee will be responsible for completion of the Environment of Care/Patient Safety Rounds at least quarterly.

~~12.~~**13.** Safety Check List**:**

a. Cords under desk - out of walk paths.

~~b. Heaters/air conditioners turned off at the end of the day.~~

~~c.~~**b.** All windows and doors locked at the end of the day.

~~d.~~**c.** Corridor doors are not to be propped open.

~~e.~~**d.** All lights out at the end of the day.

~~f.~~**e.** Nurses' station and chart cabinet locked at the end of the day.

~~g.~~**f.** All appropriate appliances/machines turned off at the end of the day.

~~h.~~**g.** No water left running;

~~i.~~**h.** All furniture and equipment placed out of walkway;

~~j.~~**i.** First Aid Kit ~~is checked monthly to insure kit~~ remains fully stocked **at all times**.
~~k.~~**j.** Fire extinguishers are checked monthly and serviced annually.
~~l.~~**k.** Fire and evacuation drills are conducted quarterly.
l. Smoke detectors are checked monthly.
m. **Emergency equipment checklist is completed monthly.**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Downtime Procedures**

ISSUE DATE: **08/11**
REVISION DATE(S): 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide guidelines and procedures for responding to Downtime.

B. **POLICY**

1. **Outpatient Behavioral Health Services** (OPBHS) staff will follow Downtime procedures by taking adequate steps to ensure continued operations.

C. **PROCEDURES:**

1. Who may perform/responsible: Tri-City **Healthcare District (TCHD)**~~Medical Center~~ Administrative and Clinical Staff.

~~1.~~**2.** Secretary and Service Coordinator Responsibilities:
   a. Notify IT by calling the help desk and notifying the manager.
   b. Request emergency cell phones from IT.
   c. Request IT help in using wireless network and connecting program and MDs.
   d. Check main voicemail and individual voicemails several times daily.
   e. Pull up progress notes for all patients for staff to document using ~~paper~~ **downtime** forms.

~~2.~~**3.** Manager or Designee Responsibilities:
   a. Notify CNE and Safety Officer
   b. Change main voicemail to indicate phone problems and to direct callers to an alternate number.
   c. Review of downtime procedure with staff to ensure completion of each task.

~~3.~~**4.** Clinical Coordinator or designee responsibilities:
   a. Notify vital departments, such as PTE and BHU.
   b. Notify patients daily in the patient community meetings.
   c. Support staff in follow through with downtime procedure.
   d. Ongoing back up of daily roster and treatment team roster to ensure that we have a back up patient schedule.

~~4.~~**5.** Nursing Responsibilities:
   a. Send an automated fax or message to vital offices, such as quality care pharmacy to inform them of our alternate fax numbers and alternate phone line.
   b. Pull up MD notes for physicians to document using ~~paper~~ **downtime** forms.

~~5.~~**6.** All Staff:
   a. Change individual messages to indicate downtime and check voicemail several times per day.
   b. Document using ~~paper~~ **downtime** forms for any work that needs to be completed for that

day.

c. If necessary, staff can go to the main campus to print sign in sheets, patient roster, etc.
d. Ideally, sign in sheets, patient roster, and schedule should be printed the day before.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Emergency Evacuation

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. Provide safe evacuation from the **Outpatient Behavioral Health Services (OPBHS)**~~Program~~.

B. **POLICY**

~~**WHO MAY PERFORM/RESPONSIBLE:** OPBHS Staff~~

1. In the case of an emergency, the program staff will evacuate all patients and visitors in a safe and orderly manner.

C. **PROCEDURE**

1. **Who may perform/responsible: OPBHS Staff**
~~1.~~**2.** The evacuation plan for the Program is prominently posted throughout the facility.
~~2.~~**3.** When a patient is admitted to the Program, the patient will be given a tour of the facility. This tour includes the location of all exits. The evacuation plan will be reviewed as part of the orientation process.
~~3.~~**4.** A quarterly fire/emergency evacuation drill shall be conducted with the patients in accordance with the hospital evacuation plan. All patients, visitors and staff are to be evacuated to a designated place. The Operations Manager, or designee, will conduct a count of all patients, visitors and staff (see **Environment of Care:** Fire ~~Safety~~**Plan – Code Red** Policy).

D. **RELATED DOCUMENT(S):**

~~4.~~**1. Environment of Care: Fire Plan – Code Red Policy**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Exchange and Replacement of Medication**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide an effective method for the exchange and replacement of expired or dispensed medications.

B. **POLICY:**
1. The Pharmacist and **Registered Nurse (**R~~.~~N~~.~~**)** are responsible for inspecting the medication storage cabinet monthly to determine completeness of stock and expired medications.

C. **PROCEDURE:**
1. Who may perform/responsible: Pharmacist and R~~.~~N.
2. The pharmacist and R~~.~~N~~.~~ inspects the contents of the medication storage cabinet monthly, for completeness of stock and expired medications.
3. The Pharmacist is responsible for returning expired medications to the pharmacy for proper disposal. The medication is then replaced and locked in the medication storage cabinet.
4. The results of the pharmacist inspection are documented **by hospital Pharmacist.**~~on the Monthly Inspection Form.~~
~~3.~~**5.** There's a psychiatric emergency box that contains medications, for emergencies only. This box is stored in the nurses' office with two secure locks. Any medications given by the RN from the emergency box must be done with a physician's order.
~~4.~~**6.** When an emergency stock medication is used, the RN enters into the Stock Medication Log, the name of the patient taking the medication, the date of administration and the dosage. Nursing will document effectiveness in a nursing note in the medical record. When the medication is depleted or out of date it is replaced by the hospital pharmacy.

D. **RELATED DOCUMENT(S):**
~~5.~~**1. Stock Medication Log**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Financial Assessment**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To accurately document the patient's financial records and screen for secondary insurance prior to patient's admission to the program.

~~B. DEFINITIONS~~

~~1. CLC refers to the Community Liaison Coordinator~~

~~C.~~**B. POLICY**

1. It is the responsibility of the hospital to pursue collection from all primary and secondary payors for services rendered by the Outpatient Behavioral Health Services **(OPBHS)**. Consequently, all OPBHS staff members are expected to adhere to Tri-City **Healthcare District's (TCHD)** ~~Medical Center's~~ Collection Policies **and**~~&~~ Procedures.
2. **TCHD**~~Tri-City Medical Center~~ must pursue collection of all deductibles and coinsurance obligations, and has in place policies and procedures that independently assess patients' ability to pay. In these instances, the **Community Liaison Coordinator's** (CLC~~'s~~) responsibility is to assist in gathering all financial information needed by **TCHD**~~Tri-City Medical Center~~ to make such a determination.

~~D.~~**C. PROCEDURE:**

1. Who may perform/responsible: ~~Community Liaison Coordinator (~~CLC~~)~~, or designated Clinical Staff

~~1.~~**2.** CLC Responsibilities:

a. Gathers all pertinent patient information and supporting documentation at the time of admission, or shortly thereafter, to assist **TCHD**~~the Tri-City Medical Center~~ in ensuring ~~maximum~~ **appropriate** reimbursement from third party payors.
b. Awareness of TC**HD**~~MC~~ policies pertaining to Charity Care, such as Administrative: **Charity Care, Uncompensated Care, Community Service** Policy # 285.
c. Obtains initial insurance authorization on all admissions to OPBHS.
d. Informs patients of any co-pays, deductibles, etc.
e. Informs patients of Charity Care Process **if applicable**.
f. Assists the patients in completing the Patient Financial Assessment Form and forward**s** the forms to Patient Financial Services.

~~2.~~**3.** CLC and Therapist Documentation:

a. Documents all verbal and telephone discussions with outside sources regarding each patient's financial status.
b. Documents all insurance authorization
c. When there is a co-pay present, the CLC will discuss the implications of this with the

potential patient.

~~3.~~**4.** Ongoing Treatment Authorization:

a. The program therapist or designee is responsible for keeping track of ongoing treatment authorizations for patients on their caseload.

b. The therapist will obtain ~~ongoing~~ **concurrent** authorizations by contacting the insurance reviewer prior to completion of authorized visits.

c. The therapist is then responsible for updating the Insurance Authorization log and with providing the program Service Coordinator with a copy of the updated log.

d. The Service Coordinator will input any authorization into the Affinity System.

e. The Service Coordinator will also obtain insurance verification on patients as requested by the CLC or manager.

~~4.~~**5.** Ability to pay should be independently determined by **TCHD**~~Tri-City Medical Center~~ in the most pragmatic manner possible. In absolutely no instance can the CLC waive any patient's financial obligations or guarantee that the patient will not receive bills. When asked by the patient whether he/she shall be billed for deductibles and/or coinsurance, the most prudent answer is that which states that it is upon the discretion of **TCHD**~~Tri-City Medical Center~~ to determine the ability to pay based upon the completed financial screen and supporting documentation. The patient must be referred back to their insurance company for verification of coverage, co-payments, etc. Furthermore, the patient must be advised that bills will be sent out by **TCHD**~~Tri-City Medical Center~~ if either the patient is deemed able to pay or the patient's financial declarations cannot be verified.

D. FORM(S):

1. Insurance Authorization Log

~~5.~~2. Patient Financial Assessment Form

E. RELATED DOCUMENT(S):

~~6.~~1. Administrative: Charity Care, Uncompensated Care, Community Service Policy # 285

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Fire Safety**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify specific guidelines for fire safety in **Outpatient Behavioral Health Services** (OPBHS).

B. **POLICY:**

~~1. **WHO MAY PERFORM/RESPONSIBLE:** OPBHS Staff~~

1. Patient and staff safety is the most important consideration. Everyone must be removed quickly and safely from the facility. The fire drill plan will be implemented at least quarterly. Documentation of the fire drills will be completed on the "Fire Drill Record". **Any p**~~P~~roblems identified ~~during implementation of plan,~~ corrective action taken, and staff participation will also be documented. ~~Refer to Tri-City Medical Center Disaster Manual.~~

C. **PROCEDURE**

1. **Who may perform/responsible: OPBHS Staff**
2. In Case of Fire:
   - ~~3.~~**a.** Utilize "R.A.C.E."
     - ~~a.~~**i.** The Procedure for Code Red is "R.A.C.E."~~—~~
       - ~~b.~~**1)** "R" Rescue people in immediate danger.
       - ~~c.~~**2)** "A" Activate the fire notification process and report the fire and the exact location.
       - ~~d.~~**3)** "C" Contain the fire by closing all doors.
       - ~~e.~~**4)** "E" Extinguish the fire with the fire extinguisher, using the P.A.S.S. method (Pull pin, Aim hose, Squeeze handle, Sweep from side to side at base of fire). Evacuate if necessary.
   - ~~4.~~**b.** The Operations Manager or designee will designate an area to which everyone in the facility will evacuate.
   - ~~5.~~**c.** The Operations Manager or designee will assign staff the following tasks:
     - ~~a.~~**i.** Announce Code Red
     - **ii.** Evacuate patients
     - **iii.** **Call 911~~/~~**
     - ~~b.~~**iv.** **Call 66 to notify main hospital**
     - ~~c.~~**v.** ~~Pull fire extinguisher~~**Attempt to extinguish**
     - ~~d.~~**vi.** Close Doors **to contain fire**
     - ~~a. Call 911~~
     - ~~e.~~**vii.** ~~Call~~ **Notify** hospital safety officer
     - ~~f.~~**viii.** Secure medical records
     - ~~b. Take head count~~

ix. Sweep the building

~~g.~~**x. Take head count once everyone is evacuated**

~~6.~~**d.** The designated staff will conduct a count of patients, visitors and staff by means of verifying patient sign-in sheets, visitor sign-in sheets.

~~7.~~**e.** Remain at the designated evacuation area until an "All Clear" is announced, which indicates that it is safe to return to the building.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Food Service Procedures**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. The program is to provide only fresh and heart healthy food for patients.

B. **POLICY**

1. Food service for the Program will be provided by Tri-City **Healthcare District**~~Medical Center~~'s **(TCHD)** Food and Nutrition Department or an outside vendor approved by the **TCHD**~~Tri-City Medical Center~~ Food ~~Service Manager.~~**and Nutrition Director.**
2. **When food is provided by an outside food service, all applicable requirements set forth in section 70273 Dietetic Service General requirement shall be adhered to**~~The Food Provider shall adhere to Title XXII Food Service Requirements for Congregate and Home Delivered Meal Service Providers~~.
3. The Operations Manager or designee will oversee the serving procedures to insure all necessary precautions are taken to avoid food contamination, i.e., proper hand washing techniques both before and after food handling, and the wearing of food service gloves. Designated staff members, and volunteer patients will be responsible for the clean-up following lunch.
4. ~~The Food Service Manager,~~**and Nutrition Director** ~~the vendor, or designee will conduct periodic inspections of the Food to determine compliance with Title XXII regarding food handling and storage.~~

C. **PROCEDURE:**

1. Who may perform/responsible: ~~Tri-City Medical Center~~**TCHD** Staff or Volunteers.
2. ~~1.~~ Serving containers and serving utensils will be sanitized daily after use. In general, disposable knives, forks, spoons, plates, bowls and cups will be used for meal service.
3. ~~2.~~ Counters, shelves and equipment shall be kept clean and maintained in good repair.
4. ~~3.~~ All food, paper and equipment supplies will be stored separately from cleaning and sanitation chemicals and/or equipment.
5. ~~4.~~ To assure maintenance of proper storage temperatures, thermometers are kept in ~~each~~ **patient** refrigerator used for food. Refrigerator temperatures will be checked daily and recorded. Temperatures outside of the established range will be re-checked in one hour. If temperatures remain higher than 40 degrees F, a work order will be placed with Engineering ~~and food will be transferred to refrigeration with appropriate temperatures.~~ **to fix the issue prior to use of the refrigerator.**
6. ~~5.~~ Refuse Disposal:
   a. Paper, cans, non-food trash and garbage which is to be disposed of will be placed in leak-proof trash cans lined with heavy leak-proof plastic trash liners~~. The cans will remain covered when not in use.~~

i. Garbage ready for removal will be securely tied and disposed of in the outdoor trash receptacles daily.
ii. Trash containers will be routinely cleaned.

b. To avoid injuries, broken glass, sharp objects and other hazards needing disposal will be placed in a separate, marked disposal container.

D. REFERENCE(S):

1. Dietetic Service General Requirements, Cal. Title 22 §70273

~~6.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Inclement Weather and Critical Incident Policy**

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish minimum standards and expectations regarding **Outpatient Behavioral Health Services (OPBHS)**~~program~~ operations during periods of inclement weather. In addition, this policy sets forth the processes and approvals necessary prior to closing **OPBHS**~~a program~~ due to severe weather conditions.

B. **POLICY:**

1. Throughout the year there are numerous situations where a decision must be made to close the **OPBHS**~~program~~ site due to inclement weather.
   a. Examples of inclement weather include, but are not limited to, fire, floods, or earthquake.

~~1.~~**2.** This policy is designed to provide overall guidance to the Operations Manager in making the decision whether to transport patients to the **OPBHS**~~program~~ site and/or close the **OPBHS**~~program~~. It is the responsibility of the Operations Manager to make a reasonable decision by balancing the safety needs of the patients with a rational and objective decision to not close the **OPBHS**~~program~~ prematurely.

~~2.~~**3.** The following are some guidelines and minimum expectations related to a specific inclement weather policy for the **OPBHS**~~program~~.

C. **PROCEDURE**

1. Who may perform/responsible: Director of Behavioral Health or designee

~~1.~~**2.** **OPBHS**~~Program~~ site closure must be consistent with other community responses; e.g., when immediate area schools, governmental agencies and Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** are closed.

~~2.~~**3.** **OPBHS**~~Program~~ site closure is prudent in the event of road closures or other serious road conditions in the immediate vicinity. Road closure is defined as those publicly announced by the proper civil authorities.

~~3.~~**4.** Staff will make every reasonable effort to arrive timely at the **OPBHS**~~Program~~. In those cases where the **OPBHS**~~Program~~ will be closed for patients, staff ~~will be required to~~**can** make phone contact to ensure that engagement with patients continues. Charting will be completed in accordance with **OPBHS**~~program~~ policy related to these phone contacts.

~~4.~~**5.** Weather conditions will be assessed throughout the day and if conditions improve sufficiently for the **OPBHS**~~Program~~ to reopen, then the **OPBHS**~~Program~~ will be reopened even if only a portion of the patients can be safely transported and only part of the **OPBHS**~~program~~ schedule can be completed.

~~5.~~**6.** Local cab services will be established by contract, as needed, for back up in the event that our usual means of transportation is not an option. Other public transportation back up systems will also be established, as needed.

~~6.~~**7.** The Director of Behavioral Health or CNE, and Safety Office will be contacted and consulted with, and must approve the final decision to close or reopen the **OPBHS**~~Program~~.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Orientation of New Patients**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To identify the process of patient orientation.

B. **POLICY:**
1. Each patient receives an orientation to the ~~Program~~ **Outpatient Behavioral Health Services (OPBHS)** by the patient's Therapist or designee. The orientation will be presented in a manner that maximizes patient understanding and the information will be reviewed as needed.

C. **PROCEDURE**
1. Who may perform/responsible: ~~Outpatient Behavioral Health Services~~**OPBHS** Staff
~~1.~~**2.** The patient will sign a copy of the ~~Program~~ **OPBHS** rules. If applicable, Dual Recovery patients sign the dual recovery program guidelines.
~~2.~~**3.** The orientation checklist is reviewed with the patient by the therapist or designee. The checklist guides the staff in orienting patients to the program. It includes information regarding rules and regulations, tour of facility, introduction to staff members, transportation procedures, sign in procedures, program schedule, evacuation procedure, procedure for calling in sick, procedure for obtaining staff assistance, lunch procedure, complaints or grievance procedure, and disclosure regarding qualifications of staff and therapists.
~~3.~~**4.** Patients will be informed of their rights and responsibilities and sign the multiple consent form, which addresses limits to confidentiality.
~~4.~~**5.** The patient will be introduced to other staff and clients during a tour of the ~~Program~~**OPBHS**.
~~5.~~**6.** Another patient (buddy) may be assigned to the new patient to assist with the orientation and acclimating to program.
~~6.~~**7.** When appropriate, the family will also receive an orientation to the ~~Program~~ **OPBHS** (typically facilitated by the Community Liaison Coordinator **(CLC)** prior to admission).
~~7.~~**8.** Orientation will include the items on the Orientation Checklist and patient orientation will be noted in the medical record.

D. **RELATED DOCUMENT(S):**
1. Orientation Checklist
~~8.~~**2. Outpatient Behavioral Health Services Rules**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Pastoral Care**

ISSUE DATE: **08/96**
REVISION~~EW~~ DATE(S): 05/98, 08/00, 10/01, 02/02, 02/033, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define availability of pastoral care, religious, and spiritual consultation to patients.

B. **POLICY:**
1. Recognizing that spiritual values and issues may affect patient response to treatment, patients will have access to a list of local clergy who have agreed to provide consultation on an as needed basis.

C. **PROCEDURE:**
1. Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) clinical and administrative staff.
2. All patients' spiritual needs are assessed in the Biopsychosocial assessment.
3. When a patient requests pastoral assistance or consultation, the ~~program~~ **OPBHS** staff will provide that patient with a multi-denominational list of local clergy or the name of **Tri-City Healthcare District's (TCHD)**~~the hospital~~ chaplain who may be available for them.
4. If assistance in contacting community clergy is necessary the ~~program~~ **OPBHS** staff will provide the patient with a telephone or assist in making the necessary arrangements.
5. If clergy is requested to come to the ~~program~~**OPBHS**, private office space will be provided for consultation.
6. Staff will maintain a supportive but unbiased relationship with patients regarding religious issues and patient's personal secular needs may be referred to community supports.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Practicum Student Placement**

ISSUE DATE: **03/05**
REVISION DATE(S): 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define guidelines for Practicum student placements (working toward a Master's Degree in Counseling or Social Work) in the ~~Program~~**Outpatient Behavioral Services (OPBHS).**

B. **POLICY:**

1. ~~Outpatient Behavioral Health Services~~**OPBHS** will accept student placements from local colleges and universities who are working toward a Master's Degree in Counseling or Social Work. The Program will provide direct supervision by a qualified, licensed clinician.

C. **PROCEDURE:**

1. Who may perform/responsible: Licensed Clinical staff
~~1.~~**2.** A contract between the school and Tri-City **Healthcare District**~~Medical Center~~ **(TCHD)** must be signed prior to the student placement.
~~2.~~**3.** Practicum students must be cleared by the Medical Center's Education Department to begin their practicum and must complete all hospital requirements to begin their internship.
~~3.~~**4.** Practicum students are directly supervised by a licensed clinician and obtain weekly individual supervision.
~~4.~~**5.** Practicum students will be assigned one to three patients to follow as their Primary Therapist and will provide group and individual therapy under the direct supervision of the Clinical Supervisor.
~~5.~~**6.** Practicum students will obtain group supervision by attending Treatment Team meetings facilitated by the Medical Director along with licensed clinicians.
~~6.~~**7.** Practicum students will present patient cases assigned to them and review the patient's treatment plan monthly in Treatment Team meetings under the supervision of the Medical Director and Clinical Supervisor.
~~7.~~**8.** Practicum students have access to a Clinical Supervisor in person or by telephone during the time they are providing services.
~~8.~~**9.** Practicum students communicate concerns regarding patients to their clinical supervisor.
~~9.~~**10.** Practicum students are aware of reporting requirements for child abuse, elder abuse, and ~~partner abuse~~**domestic violence** and keep their Clinical Supervisor informed of any possibility of abuse.
~~10.~~**11.** Practicum students are aware of steps that need to be taken when dealing with suicidal, homicidal, and gravely disabled patients and keep their clinical supervisor informed of their findings.
~~11.~~**12.** Practicum students are not able to bill for services unless services are performed along with a licensed clinician **but they must document any services provided**.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Staff Meetings**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/055, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for the **Outpatient Behavioral Health Services (OPBHS)**~~Program~~ staff meetings.

B. **POLICY:**

1. The ~~Program~~ **OPBHS** will have staff meetings and clinical problem solving meetings on a monthly basis.

C. **PROCEDURE:**

1. Who may perform/responsible: Operations Manager or designee

~~1.~~**2.** General Staff Meetings are conducted by the Operations Manager and are held monthly. All scheduled staff are expected to attend.

a. The purpose of general staff meetings are:
   i. To give staff the opportunity to discuss ~~program~~**OPBHS** administrative issues and day to day operations;
   ii. To encourage staff to participate in decision making;
   iii. To keep communication lines open between the staff and administration;
   iv. To discuss ongoing quality, performance improvement, and safety issues.

b. Staff is encouraged to submit agenda items prior to the meeting.

c. Minutes are taken and circulated to staff that are unable to attend. Past minutes are kept on file, in a binder, in the Operations Manager's office.

~~2.~~**3.** Clinical Problem Solving Meetings are held weekly concurrent with Treatment Planning meetings for all clinical ~~program~~**OPBHS** staff. The meetings are facilitated by the Operations Manager or the Clinical Coordinator and Medical Director.

a. The purpose of the Clinical Problem Solving Meeting is to:
   i. Provide the staff the opportunity to discuss challenging cases, individual patient issues and clinical concerns with the Medical Director;
   ii. To discuss and resolve milieu issues; and
   iii. To revise and plan changes in the patient's treatment schedule.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Staffing Levels**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	**12/16**
Division of Psychiatry Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To insure adequate staffing ratios for a low risk and therapeutic program.

B. **POLICY:**
1. Staffing levels are determined each day based on the number of patients scheduled.

C. **PROCEDURE:**
1. Who may perform/responsible: Director of Behavioral Health, Operations Manager or designee and Clinical Staff.
~~1.~~**2.** The staffing guidelines are used to determine staffing levels. Staffing levels are based on an average daily census.
~~2.~~**3.** Considerations for modifying staffing levels are:
   a. Orientation of new staff;
   b. Unusual programming needs, i.e., holiday programs, projected increase or decrease in census and an unusually high number of admissions or discharges; and
   c. The acuity of the patient population.

D. **STAFFING LEVELS:**
1. For **Intensive Outpatient Program** (IOP), each therapist working a forty (40) hour week will be responsible for providing an average weekly total of eighteen to twenty patient cases, ten groups per week, and admissions. Part-time staff carrying a caseload will be pro-rated accordingly.
2. When appropriate qualified professional staff members are not available or are not needed on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~- POLICY MANUAL~~

ISSUE DATE: 02/13 **SUBJECT: AGE SPECIFIC GUIDELINES**

REVISION DATE:

Department Approval:	**06/16**
~~**MEDICAL/DEPARTMENT:**~~	~~**03/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**03/13**~~
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

~~A.~~**1.** This Guideline has been developed to:

~~1.~~**2.** Address the age-specific needs of various groups of patients that may be treated at the **Outpatient Infusion Center (Center)**~~Clinic~~.

~~2.~~**3.** Provide optimal age-specific care for the patient population served in the **Center**~~Clinic~~.

B. **POLICY:**

1. The program has been designed to meet the specific medical needs of the adult/ geriatric population.
2. In the event that a patient from another age group is treated at the **Center**~~Clinic~~, age-specific guidelines will be utilized to optimize care.
3. Age-related needs will be considered in the plan of care for each patient.
4. Equipment and supplies used in the care of patients will be age-specific.
5. Other resource persons/departments will be consulted as needed to validate and enhance the care provided.
6. Employee performance appraisals will reflect age-specific evaluation.

C. **PROCEDURE:**

1. An age-specific plan of care will be developed for each patient treated at the **Center**~~Clinic~~.
2. Age-specific factors/elements of care associated with each age group will be addressed during every encounter by the clinic staff using the tables below.
3. Appropriate intervention specific to each age group will be identified during the initial visit and reviewed periodically for appropriateness and documented in the medical record.
4. Physical limitations/impairments, as well as learning or other deficits, will be considered when implementing educational/training measures and documented in the medical record.
5. The education provided will be given at the level of understanding for each patient.
6. Resource materials, persons and departments will be consulted to ensure appropriateness of the treatment plan.

D. **RELATED DOCUMENTS:**

1. Age Specific Guidelines

Age Specific Guidelines

ADULT (18~~9~~-65)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Prone to health problems related to an inability to cope with new responsibilities Suicidal tendencies, alcoholism, drug abuse, eating disorders, tobacco abuse may surface Healthcare needs are related to preventative medicine to reduce the occurrence of chronic physical or emotional problems Adjustment to menopause (females) and sexual dysfunction (males) as they approach middle adulthood		Focused on time constraints and only want to learn what is practical for them May be dual caretakers (i.e. parent and children)	Emotional stress due to mate selection, vocational selection, assuming occupational roles, marriage, childbearing, financial pressures, and independence	• Communication: Involve family in patient's care and education. When educating adult patients, explain the benefits of adhering to treatment plan; otherwise, education may not be effective. • Equipment: Refer to manufacturer's instructions.

GERIATRIC (66 and beyond)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Decreased tolerance to heat/cold	Decreased mobility	Decrease in memory, slowing of mental functions	Concern for health increases	• Patient and Family Education: Explain any instructions well to the patient & family. Don't assume that the patient understands anything. Ask the patient questions to verify understanding. Review important points repeatedly. • Communication: Explain all instructions well. Involve the patient in the examination. Use therapeutic touch as appropriate. • Environment/Safety: Keep room clutter-free; orient patient well to surroundings. Frequently assess room temperature to patient comfort. • Use of medical equipment: Refer to manufacturer's instructions.
Increased wrinkles	Decreased ability to respond to stimuli	Slower in learning	Acceptance of death	
Declining cardiac/renal function	Decreased visual acuity	Drop in performance	Decreased authority and autonomy	
Bones become more prominent/stiff joints	Hearing loss		Children leave home; become grandparents; reestablish as a couple	
Increased susceptibility to infection	Decreased tolerance to pain		Retirement/may pursue second career, hobbies	
Increased susceptibility to high blood pressure	Hesitant to respond; skills declining		Depression related to decreased physical, motor and cognitive abilities	
Shrinkage in intervertebral disc			Concern related to limited income	
Skeletal changes				
Skin changes				
Decreased organ functioning; decreased drug clearance and distribution				

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OUTPATIENT INFUSION CENTER ~~- POLICY MANUAL~~

ISSUE DATE: **032/13** **SUBJECT: DATA MANAGEMENT**

REVISION DATE:

Department Approval:	**01/17**
~~MEDICAL/DEPARTMENT:~~	**~~03/13~~**
~~DIRECTOR APPROVAL:~~	**~~03/13~~**
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Effective use and management of patient data is crucial to the service appraisal process and enhancement efforts. Properly managed data can provide vital information about:
   a. The population served
   b. Patient progress/outcomes
   c. Resources utilized
   d. Resources needed
   e. Compliance with plan of care
   f. Efficacy of the treatment plan

B. **POLICY:**

1. It is the intent of the clinic to collect and properly manage data to benefit the patients being treated at the **Outpatient Infusion Center**~~Clinic~~.
2. Patient information will be handled following all applicable confidentiality regulations and hospital policies.

C. **PROCEDURE:**

1. The patient information to be included in the patient's chart/Cerner , but is not limited to, is:
   a. Demographics
   b. Referral source
   c. Clinic physician
   d. Primary care physician
   e. Diagnoses
   ~~a. Diabetes information~~
   f. Wound assessment information
   ~~b. Wound classification~~
   g. Procedures performed
   h. Insurance information
   ~~c. Acuity of the patient~~
   i. Patient goals

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ISSUE DATE: **032/13** **SUBJECT: DIAGNOSTIC TESTS**

REVISION DATE:

Department Approval:	**06/16**
~~**MEDICAL/DEPARTMENT:**~~	~~**03/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**03/13**~~
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Timely reporting of diagnostic test results is an important aspect of planning or changing the course of treatment.

B. **POLICY:**

1. Diagnostic test relevant to the diagnosing and planning of the patient's care will be included in the electron medical record in a timely manner.
2. Ancillary/diagnostic testing may include:
   a. Laboratory
   b. Radiology

C. **PROCEDURE:**

1. The clinician will notify the **Outpatient Infusion Center's** (Center's) physician/**Allied Health Professional (AHP)** of significant findings as directed by the physician/**AHP** (telephone or fax) and document the communication in the medical record.
2. All results will be placed in the physician/**AHP** folder for review prior to placing in the patient chart. All results will be available on Cerner for review.
3. Once reviewed and initialed by the Center's physician/**AHP**, the results will be filed in the appropriate section of the patient record by the clinic staff.
4. If the ~~primary~~ Center's physician/**AHP** is unavailable for critical or significant values, the patient's primary physician or designated on-call physician will be notified.
5. Critical/significant values will be given to the Center's medical director or designee for follow-up when physician/**AHP**s involved in the care of the patient are unavailable.
6. Physician/**AHP**s will review results via Cerner.

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ISSUE DATE:	**032/13**	**SUBJECT:**	**DISSEMINATING MEDICAL INFORMATION**

REVISION DATE:

Department Approval:	**06/16**
~~MEDICAL/DEPARTMENT:~~	**~~03/13~~**
~~DIRECTOR APPROVAL:~~	**~~03/13~~**
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Patient privacy and confidentiality regulations prohibit the arbitrary sharing of medical information to protect the patient from indiscriminate use. This policy outlines the procedure the **Outpatient Infusion** Center **(Center)** follows when disseminating patient information.

B. **POLICY:**

1. All applicable State and Federal regulations and hospital policies will be adhered to when disseminating or requesting patient confidential medical data.
2. To the extent possible, medical information will be guarded against loss, destruction, tampering, and unauthorized access.

C. **PROCEDURE:**

1. Patient information will be transmitted electronically and via secure carrier from the ~~Infusion~~ Center to the **Tri-City Healthcare District (TCHD)**~~MC~~ Medical Records Department. Any information sent via fax will contain a cover sheet requesting that if the information reaches a recipient in error it should not be shared with anyone except with those for whom the information was intended.
2. If it is received in error, it is requested that the Center be notified immediately by telephone and return the original message to us at the address on the form.
3. Request for any and all ~~Infusion~~ Center records will be handled, per ~~hospital~~**TCHD** policy.

D. **RELATED DOCUMENT(S):**

~~4.~~**1. Administrative: Disclosure of Protected Health Information (PHI)**

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ISSUE DATE: **032/13** **SUBJECT: ENVIRONMENT OF CARE**

REVISION DATE:

Department Approval:	**02/16**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
~~**BOARD OF DIRECTORS APPROVAL:**~~	~~**3/13**~~

A. **PURPOSE:**

1. In order to provide a safe environment for patients, visitors and staff, this policy identifies each aspect of the hospital's safety/**Environment of Care** (EOC) program as it relates to the **Outpatient Infusion Center (Center)**~~clinic~~ environment.

B. **POLICY:**

1. Patients and visitors to the Center can expect a safe and sanitary environment.
2. Associates of the Center will be ensured of a safe and sanitary work environment.
3. Members of the staff will be competent in the safety/EOC standards set forth by ~~the hospital~~**Tri-City Healthcare District (TCHD)**.
4. The Center manager is responsible for the implementation of the safety/EOC program per ~~hospital~~ ~~**Outpatient**~~ **Center EOC** standards.

C. **PROCEDURE:**

1. All staff members will be knowledgeable of and comply with ~~the~~ **all applicable** safety standards ~~of the hospital~~.
2. The safety/EOC policies and procedures will be readily available to all associates and is located with the other ~~P&P~~**policies and procedures** manuals on the TC~~MC~~**HD** Intranet.
3. The hospital will provide safety/EOC training during the general orientation program each associate receives ~~in~~ **within** the 30-day period from the **original** date of hire.
4. A unit-specific safety orientation will be presented to the new associate within the orientation period.
5. All associates will complete the annual competency requirements of the safety/EOC program as required by ~~the hospital~~**TCHD**.
6. Safety-related incidents will be reported immediately per ~~hospital~~ **TCHD** incident reporting policy.
7. Topics/issues/plans to be addressed in unit safety/EOC presentations include but are not limited to:
   a. Safety management
   b. Disaster
   c. Emergency preparedness
   d. Life safety
   e. Utility management
   f. Bioterrorism preparedness
   g. Bomb threats/**Code Silver Active Shooter**

h. OSHA's exposure control plan for bloodborne pathogens
i. TB control plan
j. Electrical power safety
k. Loss of communication
l. Hazardous materials (includes biohazardous)
m. ~~-~~Fire safety
n. Disaster plan
o. ~~MSDS~~ **Global Harmonization SDS** program
p. Infection control plan
q. Emergency codes
r. Security plan
s. Medical equipment

~~For more specific information, refer to the hospital's Environment of Care Manual~~**~~policies and procedures on the Intranet~~**~~.~~

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OUTPATIENT INFUSION CENTER ~~– POLICY MANUAL~~

ISSUE DATE: **032/13** **SUBJECT: HISTORY AND PHYSICAL**

REVISION DATE:

Department Approval:	**06/16**
~~MEDICAL/DEPARTMENT:~~	**~~03/13~~**
~~DIRECTOR APPROVAL:~~	**~~03/13~~**
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Familiarity with the patient's medical history and current health status is essential to the plan of care developed for each patient seen at the **Outpatient Infusion Center (Center)** ~~Clinic~~. The initial process in the program consists of a thorough documentation of the patients' medical history and a physical **(H&P)** examination. Factors to the chief complaint are the main emphasis of this process.

B. **POLICY:**

1. As part of the initial evaluation, the physician will complete a history and physical documenting on the physician's notes and dictate a report incorporating the elements of the history and physical dictation outline as designated below:
   a. Chief Complaint
   b. History of Present Illness
   c. Review of Systems
   d. Physical Examination
   e. Assessment and Plan
2. As part of the preparation for ~~surgery~~ **infusion**, a pre-operative history and physical will be done that meets the following conditions:
   a. The H&P must be done prior to the procedure/admission, per hospital policy
   b. ~~If the H&P was done more than 7 days prior to the date of the surgery, the primary care physician or designee must complete the interim H&P note before admission/surgery.~~
   c. Patients receiving chemotherapy infusions must have a pre-chemo visit within 30 days of date of service, or prior to day 1 of each cycle. This visit includes review of symptoms, diagnosis and treatment plan.
   d. Patients receiving "maintenance" non chemotherapy infusions must have a pre=treatment visit every 6 months. This visit includes review of symptoms, diagnosis and treatment plan.
   ~~b.~~**e.** The patient must have medical clearance prior to any ~~surgical~~ procedure.

C. **PROCEDURE:**

1. The physician will perform the initial exam and medical history review.
2. Any staff physician, primary physician, or designee may do the pre-operative H&P and clear the patient medically for surgery.
3. The findings will be documented on the appropriate forms and dictated according to hospital policy/procedure.

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ISSUE DATE: **03~~2~~/13** **SUBJECT:** **MEDICAL EQUIPMENT MAINTENANCE**

REVISION DATE:

Department Approval:	**~~03/13~~01/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**

A. **PURPOSE:**

1. Due to the potential for injury that medical equipment poses, an effective preventive maintenance and equipment management program must be in place and strictly observed. All patient care equipment used by the clinic will be maintained in good working order and inspected and repaired according to hospital policy.

B. **POLICY:**

1. The Biomedical Department will conduct routine inspection and preventive maintenance (PM) on the **Outpatient Infusion Center's** (Center's) medical equipment on a regularly scheduled basis, according to hospital policy.
2. Staff will be trained in the proper and safe use of all medical equipment.
3. Incidents involving medical equipment will be reported according to hospital policy.
4. All employees are responsible for reporting unsafe equipment and the Clinic Manager and/or **Registered Nurse** (RN) is responsible for the continued observance and monitoring of safe use of equipment.

C. **PROCEDURE:**

1. Prior to use, all electrical devices will be inspected and approved by the Biomed Department.
2. Staff members will be trained in the proper use of electrical (or mechanical) devices prior to use.
3. Staff members are required to pull malfunctioning equipment out of use and to notify the appropriate person (biomedical engineer, clinic manager, etc.) for repair.
4. The manufacturer's operating instructions will be followed when operating medical equipment.
5. Annually, or more frequently as indicated, equipment will be inspected per hospital preventative maintenance schedule.

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ISSUE DATE: **032/13** **SUBJECT: MEDICAL RECORD REVIEW**

REVISION DATE:

Department Approval:	**01/17**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval Dates(s):	**03/13**

A. **PURPOSE:**

1. Documentation of assessment findings, procedure/treatment, etc. and appropriate signatures must always be included in the medical record. Pursuant to the hospital policy, the following defines the process used to identify incomplete records and the steps taken to correct deficiencies in the **Outpatient Infusion Center (Center)**~~Clinic~~.

B. **POLICY:**

1. All charts will be reviewed by the **Registered Nurse** (RN) ~~or LVN~~ for incomplete information after each **Center**~~clinic~~ visit prior to transferring to the health information department of the hospital to be scanned into the Cerner system.
2. Incomplete records will be returned to the appropriate **physician/Allied Health professional (AHP)**~~clinician~~ for completion.
3. The quality management/improvement process will be utilized as needed to improve the compliance with record completion.

C. **PROCEDURE:**

1. The RN ~~or LVN~~ will review the medical record for incomplete information before the patient is discharged from the clinic.
2. The RN ~~or LVN~~ will communicate the findings to the appropriate person(s).
3. When indicated, the physician/**AHP** ~~or clinician~~ will be notified of the findings to be completed within 24 hours. The completed record will be sent to the health information department for scanning into Cerner.
4. The **physician/AHP**~~clinician~~ will be responsible for ensuring that the record is completed.
   a. The RN will ~~work collaboratively with the LVN to~~ achieve record completion.
5. The hospital's medical staff rules and regulations will be followed to complete the medical record.
   a. If the record is not completed within 14 days, the medical director or designee will be notified.
   b. Identified patterns of record deficiencies will be reported to the Medical Staff Office for review.

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ISSUE DATE: 032/13 **SUBJECT: PATIENT INSTRUCTIONS**

REVISION DATE:

Department Approval:	**06/16**
~~MEDICAL/DEPARTMENT:~~	**~~3/13~~**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Patient Instructions provide the patient and family/caregivers with a clear guide to understanding the physician's/**Allied Health Professional's (AHP)** instructions for care after the **Outpatient Infusion Center (Center)**~~clinic~~ visit.

B. **POLICY:**

1. All patients receiving treatment at the Center will receive clear verbal and written instructions for aftercare/homecare.

C. **PROCEDURE:**

1. The licensed staff will transcribe orders for patient use on the approved instruction form.
2. The Center for staff will also provide verbal instructions for clarity and to assess patient understanding.
3. The next appointment date and time will be included on the instruction sheet.
4. A copy of the instructions will be given to the patient.
5. The patient will sign the form indicating receipt and understanding of instructions.
6. The patient's compliance with instructions and understanding of instructions will be assessed with each visit.

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ISSUE DATE: 032/13 **SUBJECT: PATIENT RECORD CONTENT**

REVISION DATE:

Department Approval:	**01/17**
~~MEDICAL/DEPARTMENT:~~	**~~3/13~~**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
BOARD OF DIRECTORS APPROVAL:	**03/13**

A. **PURPOSE:**
1. A systematic approach to patient record keeping is necessary:
   a. To provide consistency and orderliness
   b. For ease of use for all staff members

B. **POLICY:**
1. A medical record will be maintained in Cerner on all patients treated at the **Outpatient Infusion Center (Center)**~~Clinic~~.

C. **PROCEDURE:**
~~C.~~**1.** The order and the contents of the patient record will include, but will not be limited to:
   ~~1.~~**a.** Patient Demographics and Information:
      ~~a.~~**i.** Admission face sheet located in Cerner patient record.
   ~~2.~~**b.** Consents:
      ~~a.~~**i.** Conditions of Admission located in Cerner
   ~~3.~~**c.** History and Physical:
      ~~a.~~**i.** Documented on the physicians notes and dictated in a medical report located in Cerner.
   ~~4.~~**d.** Labs or Radiology:
      ~~a.~~**i.** Accessed in Cerner under "Labs" or "Radiology"
   ~~5.~~**e.** Physicians Orders:
   ~~a.~~**f.** Documented on the physician**'s/Allied Health Professional's (AHP**'s) notes and dictated in a medical report located in Cerner
   ~~6.~~**g.** Fax:
      i. Confirmation of faxes sent and received pertaining to patient are retained by Medical Records

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OUTPATIENT INFUSION CENTER

ISSUE DATE: 032/13 **SUBJECT: REGISTRATION OF PATIENTS**

REVISION DATE:

Department Approval:	**01/17**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. **Tri-City Healthcare District (TCHD)**~~Hospital~~ or **Outpatient Infusion Center (Center)**~~clinic~~ registration can will be completed as a pre-admit and then completed upon patient's arrival. This document outlines the registration process at the **Center**~~Clinic~~.

B. **POLICY:**

1. The clerical staff will follow the hospital's procedures for data collection and electronic data entry.

C. **PROCEDURE:**

1. Upon arrival the pre-registration will be completed.
2. All patients will be admitted to the **Center**~~Clinic~~ according to **TCHD** ~~hospital~~ policy. **TCHD**~~Hospital~~'s Conditions of Admission forms must be signed preceding any exam/treatment:

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ISSUE DATE: **032/13** **SUBJECT:** **SCHEDULING & RECEIVING OF PATIENTS**

REVISION DATE:

Department Approval:	**01/17**
~~MEDICAL/DEPARTMENT:~~	**~~3/13~~**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Establishing **Outpatient Infusion Center (Center)**~~Clinic~~ scheduling and receiving of patient:
   a. Provides for orderly, efficient approach to patient visits
   b. Minimizes patient waiting periods
   c. Allows for adequate time for evaluation/treatment
   d. Defines a uniform approach to scheduling for staff members
   e. Assigns responsibilities to avoid duplication of effort

B. **POLICY:**

1. Patients will be scheduled appropriately; allowing adequate time between visits to prevent prolonged waiting time for all patients.
2. Scheduling of patients will be directed by the Center Office Manager and coordinated by the Clinical Referral Coordinator.

C. **PROCEDURE:**

1. Patient Arrival at the **Center**~~Clinic~~
2. Patients will check in at the Reception desk with the Tri City Medical Center (TCMC) front office staff.
   a. Front office staff will obtain the necessary paperwork for the patients to complete.
   b. Front office staff will verify patient orders for treatment, identity of patient, and scheduled infusion time.
   c. Patient will be issued an identification band with name, date of birth, and medical record number.
   d. Office staff will notify Infusion **Registered Nurse (**RN**)** and Pharmacist of patient arrival for treatment.
   e. **Office Staff**~~Medical Assistant~~ will escort patient into Infusion room.

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ISSUE DATE: **032/13** **SUBJECT: SCOPE OF SERVICES**

REVISION DATE:

Department Approval:	**06/16**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
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Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**
1. The Outpatient Infusion Center **(Center)** provides outpatient therapeutic infusions and injections. The primary goal of the Center is to provide vital services to the population in need, which includes patients of multiple and differing socioeconomic and cultural backgrounds. These are patients seeking treatment for a variety of oncologic and hematologic illnesses.
2. The main objective of the program is to provide caring, progressive, state of the art patient care utilizing advanced treatment and modalities.

B. **AGE POPULATIONS:**
1. The program has been designed to meet specific medical needs of the adult population. Under special circumstances and on a case-by-case basis, needs of other patient populations may be considered.

C. **TYPES OF PATIENTS:**
1. The patients seen in the Center are the outpatient population with orders for treatment from their medical oncology practitioner or other physician**/Allied Health Professional (AHP)**.
2. Injections.

D. **CARE AND SERVICES PROVIDED:**
1. The services provided by the Center include, but are not limited to treatment including:
   a. Intravenous infusion of chemotherapeutic and other therapeutic agents.
   b. Intramuscular and subcutaneous injections of chemotherapeutic and other therapeutic agents.
   c. Intravenous hydration.
   d. Accessing and de-clotting of implanted ports.

E. **HOURS OF SERVICE:**
1. The Center is open 5 days per week, Monday through Friday, 8:00 a.m. to 5:00 p.m.

F. **STAFFING PLAN:**
1. The Center is staffed with:
   a. Medical Director.
   b. **Center**~~Clinic~~ staff members include a full-time qualified clinical manager, an office manager, nursing/clinical personnel and clerical support staff. The type and number are selected based on qualifications, experience and **Center**~~clinic~~ needs. **Center**~~Clinic~~

needs are determined by the number of active patients in the program, the type of service required by the patients and the overall requirements of the **Center**~~clinic~~. The members of the staff may include registered nurses, medical assistants, and clerical staff.

G. **PLAN FOR IMPROVING QUALITY OF CARE:**

1. The **Center**~~clinic~~ results are compared to national and/or system-wide benchmarks, when available, or the Center's own historical data. Unmet goals are perceived as opportunities for improvement. Corrective actions are relevant to improving the services rendered.
2. The quality management program is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the Center. The key elements of the program are:
   a. Collection of meaningful data.
   b. Selection of measureable indicators.
   c. A valid method of data collection, management and storage.
   d. Analysis of the data by qualified persons.
   e. Reporting to pertinent hospital personnel and committees/teams.

H. **STANDARD AND PRACTICE GUIDELINES:**

1. The policies, procedures, and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include professional practice guidelines and standards such as the Oncology Nursing Society and Nursing Intervention Research Center, and American Nurses Association.

I. **COMPETENCY/EDUCATION:**

1. Qualifications for the clinical staff of the program include:
   a. Clinical competency as determined by the level of care provided.
   b. Current State license, where applicable.
   c. Current BCLS, where applicable.
   d. Credentialing by the medical staff, where appropriate.
   e. Successful completion of ONS chemotherapy and biotherapy provider course.
2. Competence of the staff is based on:
   a. Education and training (licensing, certification and credentialing as appropriate).
   b. Ability to demonstrate the necessary skills to perform assigned duties.
   c. Years of experience.
   d. Ability to communicate effectively with the medical staff, patients, and their families.

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ISSUE DATE: 032/13 **SUBJECT: STAFFING PLAN**

REVISION DATE:

Department Approval:	**06/16**
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Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Appropriate and adequate staffing is vital to the success of the multi-service **Outpatient Infusion Center (Center)**~~outpatient clinic~~. A well-planned approach must be taken to accomplish this goal, and several factors for a good staffing plan must be considered. They are:
   a. Acuity of the patients treated
   b. Level of expertise/competency of the staff
   c. Time allotted for each visit
   d. Continuous planning and assessment (daily, weekly, monthly and yearly)
   e. Frequent review and evaluation to seek opportunities to enhance the system to benefit patient care and for good stewardship of financial resources that impact **Center**~~clinic~~ operations.

B. **POLICY:**

1. Acuity Classification: An Acuity Classification has been developed to provide for and validate adequate/appropriate resources for the plan of care for each patient who presents to the **Center**~~Clinic~~ for treatment and to support the requirements for the continuum of care activities.
2. Staffing: In general, the type and number of staff members are selected based on qualifications, experience and **Center**~~clinic~~ needs. **Center**~~Clinic~~ needs are determined daily and weekly by the number of scheduled patients, the type and acuity of patients, and the type of service required by the patients. Members of the staff may include:
   a. **Register Nurse** (RN) is empowered to run the day-to-day operations of the **Center**~~clinic~~. They also participate in the decision-making processes related to the selection of the **Center**~~clinic~~ model and the services provided. He/she is accountable for ensuring that the **Center**~~clinic~~ is adequately staffed and makes certain that patient visits are appropriate and timely.
   ~~b. Licensed Vocational Nurse, under the supervision of the RN and the direction of the RN performs duties using the nursing process to provide and maintain individualized quality patient care and participates in the coordination in the continuum of care.~~
   ~~c.~~**b.** Medical Assistant (MA), under the supervision of the RN and the direction of the RN/Case Manager ~~or LVN~~ performs tasks as assigned. The MA assists other members of the healthcare team while providing direct patient care. As a patient advocate, the MA reports observations and patient responses to care to the RN/MD and assists with maintaining patient privacy/ confidentiality and reports patient complaints of pain to the RN/MD.
   ~~d.~~**c.** Receptionist requires the coordination of the clinical, clerical and general secretarial/office duties, as well as realistic patient scheduling. The receptionist must demonstrate excellent interpersonal skills.

~~c.~~**d.** Other staff members may include a nurse practitioner/physician assistant/medical assistants, and additional clerical support staff. Competency of **Center**~~clinic~~ staff is based upon:
   i. Education and training
   ii. Years of experience
   iii. Ability to demonstrate the necessary skills to perform the defined duties
   iv. Ability to communicate effectively with the medical staff and patients and their families.

3. Patient Scheduling: Allowing adequate time for each patient visit is necessary for patient satisfaction, convenience, and care needs and is an essential component of an efficient and smooth-running clinic. To determine the time required for/between each visit, the following general rules apply:
   a. Increased time is allowed for a new patient visit or for complex cases
   b. Less time is required for follow-up and/or less-complex cases
4. Assignments: Assignments are planned by the clinical manager/case manager on a weekly basis and are based upon the number of patients scheduled, assessment of clinical needs of the patient, the complexity of the patient's condition, and the clinical care requirements. Staffing levels may be adjusted to correspond with the anticipated care requirements. In addition, the **Center**~~clinic~~ manager/coordinator reviews the changes in the daily **Center**~~clinic~~ schedule and makes necessary adjustments to staffing levels.
5. Evaluation of Staffing Plan: The staffing plan is periodically reviewed and evaluated by the **Center**~~Clinic~~ Manager. Opportunities for improvement/enhancement are identified, and changes are made consistent with the needs of the patients and the staff members.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 032/13 **SUBJECT: STANDARDS OF CARE**

REVISION DATE: 03/13

Department ~~Director~~Approval:	**~~03/13~~06/16**
Division of Oncology~~Medical/Department~~ Approval:	**~~03/13~~03/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE**

1. Standards of care and practice must be delineated with the following objectives in mind:
   a. Provide patients and their families with an understanding of the services provided by the **Outpatient Patient Infusion Center** (Center).
   b. Meet patient/family expectation, which is to have competent care providers when being treated at the Center.
   c. Define the standards of care and practice as required by governing and oversight bodies such as the Department of Health Services (DHS), Centers for Medicare and Medicaid (CMS) **and**~~&~~ The Joint Commission (~~T~~JC)~~,~~.

B. **POLICY**

1. All clinical staff will follow the Nurse Practice Act and Standards of Care and Practice,~~ and~~ Consensus Standards from the Oncology Nursing Society (ONS) **&and** American Society of Clinical Oncology (ASCO) in the delivery of patient care.
2. The Center will operate according to the established standards, which addresses all aspects of care.
3. The standards of care and practice will be consistent with care and practice standards and mission of **Tri-City Healthcare District (TCHD)**~~the hospital~~ but will be specifically designed for the ~~outpatient~~ services provided at the Center.
4. Standards will be developed collaboratively with other relevant disciplines to maintain constancy in the level of care provided throughout the institution.
5. All activities including treatment plans, policies and procedures, documentation and performance improvement measures will correlate with the approved standards of care and practice.

C. **PROCEDURE**

1. The clinical manager/medical director and the clinical staff of the Center are responsible for developing the standards of care and practice.
2. The hospital format is utilized and defines the:
   a. Standard of care as the expected outcome
   b. Standard of practice as the scope of service, the person responsible, and the timeframe for completion
3. The standards will be reviewed and approved by Patient Care Services prior to implementation.
4. All policies and procedures will be developed/revised utilizing the established standards.
5. The performance improvement (PI) efforts will incorporate the standards in the PI activities.
6. The designated infusion center team will review the standards biannually.
7. The Standards of Care and Practice are delineated on the following pages.

D. RELATED DOCUMENT(S):

~~7.~~1. Outpatient Infusion Center: Standards of Care

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	1. The patient will have a competent and qualified registered nurse responsible for planning, directing and evaluating his/her care.	RN	Ongoing	1. The clinician systematically evaluates the quality and efficacy of nursing practice. Participates in performance improvement (PI) activities as appropriate to the individual's position, education and training, and practice environment. • Identifies key functions important for monitoring • Identifies measures used to monitor quality and efficacy of patient care • Collects data to monitor quality and efficacy of patient care • Analyzes data to identify opportunities for improving care • Make recommendations to improve nursing practice • Participates with team efforts to evaluate clinical practice or health services • Assists with the development of policies and procedures to improve performance. b. Use PI information to initiate change in practice c. Use PI information to initiate change in healthcare delivery 2. The clinician evaluates his/her own nursing practice in relation to professional practice standards and relevant statutes and regulations. a. Engages in performance self-appraisal on a regular basis, identifying areas of strength, as well as areas for professional practice development b. Seeks constructive feedback regarding his/her own performance c. Takes appropriate action to achieve identified goals d. Participates in peer review, as appropriate 3. The clinician maintains proficiency in current professional activities. a. Maintains current state licensure b. Meets the current mandatory educational requirements for employees of the hospital including completion of the orientation and annual reorientation processes c. Has knowledge of and uses established hospital and Center policies and procedures in accomplishing patient care d. Meets or exceeds performance standards as indicated on the annual performance appraisal e. Participates in ongoing educational activities relevant to current practice f. Seeks experience to maintain skills g. Participates in and seeks knowledge about the activities associated with the continuum of care 4. The clinician contributes to the professional development of peers as well as the other levels of caregivers

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	(continued)	RN	Ongoing	a. Shares knowledge and skills with colleagues and others b. Provides the Center's staff with constructive feedback regarding practice c. Contributes to an environment favorable to ongoing clinical education 5. The clinician collaborates with the patient/family/caregiver and healthcare providers in providing consistent care. a. The clinician communicates with the patient/family/caregiver regarding patient care and nurse's role in the provision of care b. The clinician consults with healthcare providers including pharmacist for patient care as needed c. The clinician makes appropriate referrals to agents/agencies for continuity of care d. The clinician collaborates with interdisciplinary staff as appropriate to coordinate all aspects of care 6. The plan of care and the provision for care is conducted in a manner that protects and advocates on behalf of the patient. a. The State's Nurse Practice Act guides the nurse's practice b. The clinician ensures the confidentiality of the patient/family c. The clinician acts as the patient/family advocate d. The clinician delivers care in a non-judgmental and nondiscriminatory manner that is sensitive to the diversity of individual patient needs e. The clinician delivers care in a manner that preserves and protects patient autonomy, dignity and rights f. The clinician seeks appropriate resources to help formulate ethical decisions 7. The clinician uses research findings in practice. a. The clinician uses interventions substantiated by research, which are approved as appropriate to the individual's scope of practice, position, education and practice environment b. The clinician participates in research activities as appropriate to the individual's scope of practice, position, education and practice environment
Aspects of Care	2. The patient will have care and interventions directed toward the support and maintenance of normal and improved physiological status and not experience avoidable complications	RN	Ongoing	The clinician will: 1. Assess the patient's current health status and pertinent information of present and past history. 2. Collaborate with physician and other healthcare providers in planning care. 3. Observe and report signs and symptoms of complications. 4. Provide nursing interventions as appropriate. 5. Document all findings of assessments, interventions and changes of the plan of care.

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care (continued) Aspects of Care	3. The patient will have care and interventions directed toward support of emotional, psychological and spiritual needs.	RN RN	Ongoing Ongoing	The clinician will: 1. Assess patient needs, identify desired outcomes, and design specific nursing interventions to achieve goals involving: a. Emotional needs • Observes behavior that reflects patient's emotional needs • Assesses possible contributing factors for behaviors • Determines needs related to behaviors • Identifies resources for meeting the emotional needs b. Psychological needs • Supports the patient during tests/procedures • Encourages questions and expression of feelings • Makes appropriate professional referrals for counseling, as appropriate • Provides for patient privacy c. Spiritual • Acknowledges and supports the patient's religious prohibitions/ restrictions, etc. 2. Evaluate effectiveness of intervention and documents in the patient's record
Aspects of Care	4. Before initiation of a chemotherapy regimen, each patient is given written documentation, including, at minimum:	RN	Ongoing	a. Information regarding his/her diagnosis b. Goals of therapy c. Planned duration of chemotherapy, drugs, and schedule d. Confirm with the patient his/her planned treatment prior to each cycle; e. f. Information on possible short- and long-term adverse effects g. Regimen- or drug-specific risks or symptoms that require notification and emergency contact information, including: • How to contact the practice or organization; • Symptoms that should trigger a call; • Who should be called in specific circumstances (oncologist or other provider) h. Plan for monitoring and follow-up i. Patient education materials should be appropriate for the patient's reading level/literacy and patient/caregiver understanding.

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	5. On each clinical visit or day of treatment during chemotherapy administration, staff:	RN	Ongoing	A. Assess and document clinical status and/or performance status B. Document vital signs and weight C. Verify allergies, previous reactions, and treatment-related toxicities D. Assess and document psychosocial concerns and need for support; taking action when indicated. E. At each clinical visit or day of treatment during chemotherapy administration, staff will review the patient's current medications including over the counter medications and complementary and alternative therapies. Any changes in the patient's medications are reviewed and documented by a practitioner during the same visit.
Environ-ment	The patient can expect to be treated in a safe, sanitary, comfortable and therapeutic environment.	All staff	Ongoing	1. The staff will: a. Assure that equipment and supplies will: • Be maintained in good/safe working order • Be readily available • Be kept clean b. Dispose of waste properly by following hospital waste policies including • chemotherapy safety and handling policies • biohazardous waste policy & procedure • Sharps use & disposal policy & procedure c. Take measures that prevent cross-infection and transmission of potentially infectious/communicable microorganisms by: • Following hospital transmission-based precautions as it relates to the practice in the clinic • Handwashing/hand antisepsis (1) Before and after patient contact (2) Before and after contact with patient wounds (3) Before performing or assisting with clinic procedures (4) After contact with contaminated surfaces/equipment (5) After contact with body substances or mucous membranes • Maintain aseptic and clean technique, as appropriate • Maintain a clean and sanitary environment d. Provide for patient's safety by: • Locking wheels of chairs, wheelchairs when transferring or assisting patients from one area to another

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				• Never leaving disoriented/confused patients unattended • Assisting patients with visual deficit when ambulating • Assisting patients with unsteady gait when navigating around the clinic • Placing call bells at every patient chair • Placing personal belongings as close as possible to patient • Using appropriate equipment based on age and size e. Providing assistance and protection in life-threatening events by: • Following hospital's emergency procedures, e.g., fire, disaster, security, etc. • Following emergency cardiac event protocol
Assessment	The patient will be assessed for his/her biophysical, psychological, social, nutritional, functional, comfort and educational needs to determine the course for the plan of care.	RN/PT	Initial visit	1. During the initial visit the clinician will: a. Complete or assist patient with completing the general information requirements and include information, as appropriate, from family members, friends, caregivers and care providers. b. Review available medical history records c. Record relevant medical data including: • Laboratory findings • Allergies • Current medication • Activities of daily living • Nutritional status • Mobility • Social habits such as consumption of tobacco, caffeine, alcohol, and recreational drugs • Past and present medical history • Past hospitalizations, surgeries, invasive procedures • Review of systems • Vital signs - TPR & BP • Pain assessment • Evidence of, or suspicion of, abuse d. Assess pain e. Assess barriers to learning functional assessment f. Evaluate home environment g. Assess transportation needs j. Complete an appropriate age-specific assessment for the adolescent, adult and geriatric patient that includes consideration for: • Growth & development • Emotional needs • Cognitive status

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Assessment	(continued)	RN	Initial visit	• Educational needs • Social needs • Daily activity needs
Reassess-ment	The patient will be reassessed for compliance and response to treatment at each visit.	RN	Ongoing	The patient is reassessed at each visit for: 1. Compliance with the plan of care a. Response to treatment b. Understanding of home instructions c. Changes in care, medication, new illness, hospital visits d. Wound condition e. Supply/equipment needs f. Signs and symptoms of complications g. Continuing care needs h. Pain level i. Mobility status j. Mental status k. Educational needs l. Acuity
Patient/ Family Education	The patient/family/ caregiver will be knowledgeable about the nature of the patient's illness and will be included in the plan of care and the treatment procedures necessary to restore the patient back to optimal health. (continued)	RN	Ongoing	Nursing will: 1. Assess and document the level of understanding that the patient/family caregiver demonstrates about the patient's illness and healthcare needs. 2. Assess and document the patient's ability and readiness to learn. 3. Develop individualized teaching/learning plans. 4. Collaborate with the clinic physician and other team members to provide continuity of the teaching plan. 5. Provide support and information to patient/family to include: a. Orientation to the Center program b. Explanation of tests and procedures c. Safe and effective use of medications and expected responses and side effects d. Safe and effective use of equipment and supplies e. Patient care techniques f. When to call and how to reach the center
Patient/ Family Education		RN	Ongoing	

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				g. Access to available community services h. Obtaining assistance from other health disciplines 6. Utilize appropriate teaching methods and tools 7. Evaluate the effectiveness of the teaching 8. Document learning assessments and interventions and patient/family response to educational efforts
Patient Rights	The patient will have a sense of acceptance as a person and of value as a human being and will maintain a sense of personal identity	All clinic staff	Ongoing	The staff will: 1. Protect, to the extent possible, all patient information according to all applicable regulatory and hospital requirements. 2. Approach the patient with a respectful and compassionate attitude by: a. Conveying a sense of concern and warmth b. Identifying themselves at each encounter c. Responding appropriately to patient needs 3. Assist patient to maintain a sense of personal identity by: a. Communicating what the patient can routinely expect, as well as the tests, procedures and treatments performed b. Respecting the patient's right to inquiry and information regarding their illness, the plan of care and associated procedures/treatments c. Making patients/family aware of their rights and the procedure to follow when they have complaints or concerns d. Encouraging patient/family participation in planning care e. Acting as patient advocate f. Use patient's proper name or the stated preference

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~- OCEANSIDE POLICY MANUAL~~

ISSUE DATE: **03~~2~~/13** **SUBJECT:** **~~UNIT~~DEPARTMENT-SPECIFIC ORIENTATION**

REVISION DATE:

Department ~~Director~~Approval:	**~~03/13~~06/16**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Because of the complexity of the services offered, comprehensive orientation to the processes and protocols of the Outpatient Infusion Center **(Center)** is essential to adequately prepare associates to work in this environment. This document delineates the responsibilities of **Tri-City Healthcare District (TCHD)**~~the hospital~~, the ~~Infusion~~ Center and the associate and defines the processes necessary for equipping each employee to safely/effectively perform his/her job duties.

B. **RESPONSIBILITY:**

1. **TCHD**~~The hospital~~ assumes responsibility for the initial and annual orientation programs.
2. The department is responsible for ~~unit~~**department**-specific orientation, the ~~unit~~**department**-specific safety and environment of care training and for staff development programs throughout the year that meet the identified needs of the staff and the **Center**~~clinic~~ operations.
3. The **Center**~~clinic~~ manager assumes overall responsibility for the design, implementation and evaluation of the orientation process.
4. The associate, in partnership with the hospital assumes responsibility for:
   a. Professional education/licensing and certifications.
   b. Identifying their own learning needs.
   c. Pursuing opportunities to meet their learning needs.

C. **POLICY:**

1. All employees joining the Center team will have a ~~unit~~**department**-specific orientation and training.
2. The orientation/training content will be current, applicable, and systematic.
3. The orientation/training experience is individualized and designed to provide pertinent policy and procedural knowledge to be followed by the new associate.
4. Instruction will be clear, succinct, and administered at the level of the learner.
5. Competency assessments, where applicable, will be completed before the end of the ~~unit~~**department** orientation and filed in the associate employment folder in the **Human Resources** department.
6. Orientation will be provided during the associate's assigned work shift.
7. Orientees will be acquainted with their new surroundings and receive sufficient orientation and training to become a member of the ~~Infusion~~ Center team.
8. Cross training of an associate may also occur when appropriate. The training will be sufficient in content and duration to prepare the associate for their new position.

D. **PROCEDURE:**

1. All associates will receive general **TCHD**~~hospital~~ orientation.
2. Department-specific orientation and training will occur in the initial period of the associate's employment and prior to taking full responsibility for their assigned duties.
3. A job description will be given to each orientee.
4. The duration of the orientation period will be sufficient to prepare the employee for full participation in Center activity.
5. Each new staff member will be assigned to a resource person(s) by the manager.
6. During the 90-day initial employment period, the new employee will be observed by the Center manager and/or designee for progress and adjustments to the training will be made accordingly.
7. Department-specific orientation schedule includes:
    a. All Center staff members
        a. Job descriptions
        b. Safety
            1) MSDS
            2) Emergency plans (fire, disaster, etc.)
            3) Hazardous waste
        c. Infection control
            1) Standard (Universal) precautions
            2) Personal protective equipment
            3) Biohazardous waste
            4) Hand washing
        d. Review of abuse report policy
        e. Performance improvement program
        f. Risk management program
    b. Clinic staff orientation
        a. ~~Unit~~**Department** orientation
        b. Center policies and procedures
        c. Clinic flow
        d. Equipment
            1) Infusion pumps
            ~~2) Glucometer~~
            ~~3)~~**2)** Pyxis supply and medication station
        e. Blood drawing/transporting/storage techniques
        f. Medical records/documentation
        g. Supplies/protective devices
        h. Cerner documentation system
    c. Support staff
        a. ~~Unit~~**Department** orientation
        b. Center flow
        c. Medical records
        d. Database
        e. Bill/reimbursement/registration
        f. Phone techniques/etiquette
        g. Equipment
            1) Copier
            2) Fax
            3) Computer/printer
            4) Telephone system
        h. Cerner documentation system

Tri-City Medical Center
Oceanside, California

PHARMACY ~~SERVICES POLICY~~

ISSUE DATE:	**01/99**	**SUBJECT:**	**Automatic I.V. to Oral Conversion**
REVISION DATE:	**03/00, 02/03, 06/05, 07/06, 01/12 06/14**	**POLICY NUMBER:**	**8390-6012**

Department Approval:	**03/17**
Pharmacy & Therapeutics Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 3/14~~05/17**
Medical Executive Committee Approval:	**~~06/05, 07/06, 07/09, 1/12, 5/14~~06/17**
Professional Affairs Committee Approval:	**~~6/14~~07/17**
Board of Directors Approval:	**~~06/05, 07/06, 07/09, 1/12,~~ 06/14**

A. **PURPOSE:**

1. To provide a process for changing select parenteral medications to the oral or enteral route when medically appropriate in order to reduce cost, hospital length of stay, and associated risks with continued intravenous therapy while maintaining equivalent clinical outcomes

B. **POLICY**:

1. The clinical pharmacist will review patient profiles, current progress notes, pertinent labs, and discuss patient status with the patient's nurse or physician to determine eligibility for IV to PO conversion. If the patient meets approved criteria, the clinical pharmacist will transition the patient to oral therapy upon authority of the Pharmacy ~~&~~ **and** Therapeutics **(P&T)** Committee
2. Such therapeutic conversions will be reviewed and revised at least annually
3. A complete list of approved IV to PO conversions shall be available on the Tri-City Medical Center intranet (see attachment)

C. **PROCEDURE**:

1. IV to PO conversion may be executed by pharmacists after prescribers have been advised of the policy set forth by the Pharmacy and Therapeutics Committee. Such medication conversions will be automatic and notification to each individual prescriber will be communicated via a progress note entered in the patient's chart
2. Only medications with prior P&T approval may be automatically converted by pharmacists
3. Pharmacists will evaluate all adult patients for potential IV to PO conversion after receiving at least one dose of intravenous therapy and have been hospitalized for at least 24 hours
   a. **Exception: Orders for IV levothyroxine will be held for up to 5 days in patients that were compliant with oral therapy prior to admission unless specifically ordered by physician not to hold IV levothyroxine, endocrinology is consulting on the patient, or patient has been diagnosed with myxedema coma. The pharmacist will discontinue the original IV levothyroxine order and enter a "Levothyroxine Consult" order as a placeholder. During the 5 day hold period, the patient may be converted to oral levothyroxine if eligible per policy. If after 5 days patient remains ineligible for oral conversion, IV levothyroxine will be initiated as per the original order**

~~3.~~**4.** If the patient is being considered for an IV to PO conversion, the clinical pharmacist will examine the route of therapy and determine if it is clinically appropriate to perform a parental to oral therapy switch

~~4.~~**5.** If the patient meets the approved criteria and none of the exclusion criteria for transition to oral therapy, the clinical pharmacist will enter a new order via CPOE using the same physician name as the original order and will include the drug name, dose, route, and frequency. Any special

instructions and "per Pharmacy IV to PO Protocol" will be entered in the order comments. The order shall be electronically signed by the pharmacist, "Per Pharmacy Protocol." The pharmacist shall discontinue the intravenous medication ordered by the physician to prevent duplication in therapy

~~5.~~**6.** The new order stop date will be changed by the pharmacist to reflect that of the original order

~~6.~~**7.** If a drug-food interaction exists that can alter absorption of the medication (i.e levofloxacin and iron, antacids, calcium, sucralfate), the pharmacist will change administration times of the drug to avoid such interaction

~~7.~~**8.** In the event the physician wishes to opt out of automatic IV to PO conversion, the physician shall write in the order comments of the IV order "No IV to PO conversion." The physician may also order an Rx Note stating "No IV to PO conversion" to cover all medications. Such instructions should also be documented in the latest progress note.

~~8.~~**9.** Any orders that are changed back to the IV form will be referred for clinical review and discussion with the prescribing physician

~~9.~~**10.** Prior to writing an order to change the medication to the oral (or enteral) route, all of the following criteria must be verified:

a. Inclusion Criteria:
   i. Patient is improving clinically
   ii. Tolerating food or enteral feeding for at least 24 hours **(may be NPO if cleared for, and tolerating other oral medications)**
   iii. Able to adequately absorb oral medications via the oral, gastric tube, or nasogastric tube route
   iv. Has not received anti-emetics within the last 24 hours
   v. Patient adherence to oral therapy is anticipated
   vi. Does not display signs of shock; not on vasopressor blood pressure support
   vii. Taking other medications via the oral, gastric tube, or nasogastric tube route
   viii. Does not have any contraindications to oral or enteral medication administration
   ix. Additional requirements for antimicrobials:
      1) Blood cultures negative at 72 hours
      2) Afebrile for at least 24 hours (T <100.4F or 38C)
      3) Heart rate ≤ 90 BPM
      4) Systolic blood pressure ≥ 90 mmHg (without vasopressor drugs)
      5) RR ≤ 20 BPM
      6) Signs and symptoms of infection have improved or abated
         a) Improving or normalized WBC and differential counts
         b) Clinical improvement at site of infection
         c) Hemodynamically stable
         d) Patient is not septic

c. Exclusion Criteria:
   i. Persistent nausea, vomiting and/or diarrhea
   ii. Difficulty swallowing, refuses oral medication, or is strict NPO for a procedure
   iii. Altered mental status or aspiration risk and no NG access
   iv. Experienced severe trauma within last 72 hours
   v. Patient with the following GI conditions:
      1) Known or suspected ileus with no active bowel sounds
      2) Known or suspected malabsorption syndrome, motility disorder, short bowel syndrome, partial or total removal of the stomach
      3) Known or suspected gastrointestinal obstruction
      4) High nasogastric output (greater than 500ml/day) or requiring continuous GI suction
      5) Continuous tube feedings that cannot be interrupted and patient requires a medication known to bind to enteral nutrition formulas (levothyroxine)
      6) Active GI bleed
      7) Receiving neuromuscular blocking agents

vi. Cystic Fibrosis exacerbation
vii. Patients with Grade III or IV mucositis
viii. Wernicke's encephalopathy (Utilizing high dose thiamine 500 mg IV q8h x 48 hours then 500 mg IV daily x 5 days. May switch to thiamine 100 mg po daily indefinitely once tx course complete)
ix. Hx of heavy ETOH use (Must receive 100 mg IV daily for at 3-5 days prior to thiamine interchange)
x. Myxedema coma or if endocrine consulting (for IV levothyroxine)
xi. Actively seizing or at high risk for recurrent seizures or if neurology consulting (for levetiracetam)
xii. Patient's condition is rapidly changing such that their ability to tolerate oral medication may be compromised within the next 24 hours
xiii. Any situation in which the patient is currently receiving other oral medication and/or food but the pharmacist or other healthcare provider questions the current suitability of this route
xiv. Additional requirements for antimicrobials
1) Patient has a serious or life threatening infection which include but not limited to: Meningitis, endocarditis, endovascular infections, inadequately drained abscess or empyema, necrotizing fasciitis, osteomyelitis, septic arthritis, bacteremia, legionella pneumonia, invasive candidiasis
2) Immunocompromised (i.e on concomitant immunosuppressive, recent chemotherapy, chronic steroid use, HIV infection)
3) WBC less than (<) 4 or greater than (>) 12 or ANC < 500
4) Temp ≥ 100.4F or 38C or Temp ≤ 98.6F or 36C
5) HR> 90 BPM or SBP< 90 mmHg
6) RR greater than (>) 20 BPM or PaCO2 greater than (>) 32 mmHg
7) Candidemia or bacteremia treated less than 7 days
8) Other infections which require extended intravenous therapy
9) Severe C.dif requiring IV ~~flagyl~~ **metronidazole** and **oral**~~po~~ vanco**mycin where**~~.~~ s~~S~~witching to oral metronidazole offers no benefit

D. **RELATED DOCUMENT(S):**
1. Automatic I.V. to Oral Conversion Medication Tables

Automatic I.V. to Oral Conversion Medication Tables

Table 1: GI drugs Eligible for IV to PO Conversion			
Dosing Suggestions			
Indication	**IV Regimen**	**PO Regimen**	**Enteral Feeding tubes**
SRMD Prophylaxis	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po BIDAC	Lansoprazole 30mg DHT/NG/OG/PEG q24h Famotidine 20mg DHT/NG/OG/PEG q12h
*NSAID-induced ulcer prophylaxis	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	Lansoprazole 15mg DHT/NG/OG/PEG daily Famotidine 20mg DHT/NG/OG/PEG q12h
*Symptomatic GERD	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	Lansoprazole 15mg DHT/NG/OG/PEG daily Famotidine 20mg DHT/NG/OG/PEG q12h
*Erosive esophagitis	Pantoprazole 40mg IV q24h Famotidine 20-40mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20-40mg po BIDAC	Lansoprazole 30mg DHT/NG/OG/PEG daily Famotidine 20-40mg DHT/NG/OG/PEG q12h
*Hypersecretory Disorders	Pantoprazole 80mg IVP BID Famotidine 20mg IV q6h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po q6h	Lansoprazole 60mg DHT/NG/OG/PEG daily Famotidine 20mg DHT/NG/OG/PEG q6h
*Active duodenal ulcer	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 40mg po QHS or 20mg BIDAC	Lansoprazole 15mg DHT/NG/OG/PEG daily Famotidine 40mg DHT/NG/OG/PEG q24h or 20mg q12h
*Active gastric ulcer	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 40mg po QHS	Lansoprazole 30mg DHT/NG/OG/PEG daily Famotidine 40mg DHT/NG/OG/PEG q24h

Table 2: Antimicrobials Eligible for IV to PO conversion		
IV Drug Regimen:		Convert to:
Drug	IV Dose	Oral Conversion
Azithromycin	250mg IV q24h 500mg IV q24h	250mg po q24h 500mg po q24h
Ciprofloxacin	400mg IV q24h 400mg IV q12h 400mg IV q8h	500mg po q24h or 250mg po q12h 500mg po q12h 750mg po q12h
Doxycycline	100mg IV q12h	100mg po q12h
Fluconazole	100mg-400mg IV q24h	100mg-400mg po q24h
Levofloxacin	250mg-750mg IV q24h-q48h	250mg-750mg po q24h-q48h
Linezolid	600mg IV q12h	600mg po q12h
Metronidazole	250mg IV q6h or q8h 500mg IV q6h or q8h	250mg po q6h-q8h 500mg po q6h-q8h
Sulfamethoxazole/trimethoprim (Bactrim or Septra)	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses

Table 3: All Other Medications Eligible for IV To PO Conversion		
IV Drug Regimen:		Convert to:
Drug	IV Dose	Oral/Enteral Feeding tube Conversion
Acetaminophen	1000 mg IV Q6H	1000 mg PO Q6H
Levothyroxine	12.5mcg-100mcg IV daily	2 x IV dose (25mcg-200mcg po AC-BFK)
Levetiracetam	250-1500mg IV q12h-q24h	250-1500mg po q12h-q24h (same dose regimen)
Thiamine	100mg IV q24h	100mg po q24h (same dose regimen)
Folate	0.5-1mg IV q24h	0.5-1mg po q24h (same dose regimen)

Tri-City Medical Center
Oceanside, California

PHARMACY ~~SERVICES POLICY MANUAL~~

ISSUE DATE: 11/11

SUBJECT: Pharmaceutical ~~Vendors~~Representatives

REVISION DATE: 03/12
~~REVIEW DATE:~~

~~POLICY NUMBER: 8390-10025~~

Department Approval:	**~~05/15~~04/17**
Pharmacy and Therapeutics Committee Approval:	**~~03/12; 05/15~~05/17**
Medical Executive Committee Approval:	**~~03/12; 07/15~~06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	**03/12**

A. PURPOSE:

1. Interactions between medical centers and industry are vital to public health, but they must be conducted in a way that is principled and upholds the public trust.
2. The purpose of this policy is to address the specific interactions between Tri City **Healthcare District**~~Medical Center~~ ("TC**HD**~~MC~~") personnel and the pharmaceutical vendor industry.

B. SCOPE:

1. **Applicable to all medical, nursing, pharmacy, and other healthcare professionals at TCHD~~MC~~.**
2. **All pharmaceutical representatives (including but not limited to sales representatives and medical science liaisons).**

~~B.~~**C. DEFINITION(S): ~~OF GIFTS:~~**

~~1. A gift is defined as anything of value that is given by a business or individual that does or seeks to do business with TCMC and for which the recipient neither paid nor provided services.~~

~~2. Gifts may include but are not limited to:~~

~~a. Cash in any amount~~
~~b. Any product or service, or discounts on products or services~~
~~c. Prizes~~
~~d. Gift certificates~~
~~e. Tickets~~
~~f. Loans~~
~~g. Meals, Food or Beverages~~
~~h. Transportation~~
~~i. Hotel accommodations~~
~~j. Use of company vehicles or vacation facilities~~
~~k. Stocks or other securities, participation in stock offerings~~
~~l. De minimis items, e.g. trade show trinkets distributed to large numbers of people by vendor representatives. This does not include materials of de minim is value which have a clear educational value, such as patient friendly booklets.~~
~~m. Group items or services from vendors meant to be shared by all members of the staff, e.g. flowers or chocolates)~~
~~n. Vendor invitations to be their guest at charitable events whether or not sponsored by Tri City Medical Center~~
~~o. Promotional items such as pens, pads or other office supplies featuring product or company names~~

1. Gift: Any favor, discount, hospitality, loan, forbearance, gratuity, or other item having economic value.
   a. Excludes food or meals provided as part of an educational presentation/meeting and items of educational value (such as text books) that are $100 or less in value.
~~3.~~2. Pharmaceutical representative: An employee or consultant representing the interests of one or more pharmaceutical manufacturers by providing educational material and/or promoting the sale of drug products.

~~C.~~D. ~~Special Examples~~POLICY:
1. The Pharmacy Clinical Manager or his/her designee is the primary point of contact for all pharmaceutical representatives conducting business within TC~~MC~~HD.
2. Signed Statement:
   a. Each pharmaceutical vendor must sign a statement acknowledging his/her familiarity with this policy.
   b. A copy of this policy will be presented for acknowledgement to all pharmaceutical vendors via RepTrax.
3. Scheduling Appointments:
   a. Pharmaceutical vendors are not permitted on the TCHD~~MC~~ campus without an appointment approved by the Pharmacy Clinical Manager.
   b. Appointments will be limited to business hours (Monday – Friday 0800-1700) unless specific authorization is given by the Pharmacy Clinical Manager on a case by case basis.
4. Permitted Activities:
   a. With prior approval, pharmaceutical sales representatives are allowed in the facility for the following activities at the request of the Pharmacy Clinical Manager or designee:
      i. To provide educational programs and scheduled in-services. See section Educational Programs below.
      ii. To exhibit informational / promotional displays in assigned areas. See section Drug Displays below.
5. Physician Contact by Sales Representatives:
   a. Contact with physicians on hospital property requires the prior approval of the Pharmacy Clinical Manager.
   b. Contact with physicians is limited to those services having offices on the hospital premises (e.g., radiology staff, cardiology services staff).
   c. Contact with physicians at their office regarding Pharmacy and Therapeutics Committee activities is not permitted.
6. Restricted Formulary:
   a. Pharmaceutical sales representatives must promote products according to approved FDA guidelines and facility approved guidelines.
   b. Medications not on the formulary may not be promoted unless so authorized and with the permission of the Pharmacy Clinical Manager.
7. Prohibited Activities:
   a. Presenting false, undocumented, misleading statements or claims to any physician or other healthcare professional associated with the hospital, whether or not made while on hospital or campus grounds, that serve to misrepresent a drug's usage in therapy.
   b. Distributing gifts.
   c. Providing information or distributing promotional material regarding non-formulary, newly-approved, restricted or non-contracted drugs within the facility, without first obtaining approval in writing from the Pharmacy Clinical Manager. This includes providing and distributing information to Pharmacy & Therapeutics (P&T) and Medical Executive Committee (MEC) members.

d. Exhibiting drug displays is strictly prohibited, unless requested by the Pharmacy Clinical Manager and approved by administration prior to display.
e. Distributing pharmaceutical samples at the hospital (and acceptance by hospital staff) is strictly prohibited except as specifically outlined in the Pharmacy Services Policy: "Drug Samples".
f. Obtaining or completing any part of the hospital's Formulary Request Form.
g. Soliciting the names of the Pharmacy and Therapeutics Committee members or other related committee with regard to the formulary management process.

8. Site Access and Hospital Security:
   a. Upon entering the facility, pharmaceutical sales representatives will check in at the RepTrax kiosk located in the Main Lobby.
   b. The representative is required to wear an identification badge provided by the RepTrax kiosk.
   c. Representative must be escorted to the area to be visited and accompanied, at all times while in the facility, by a hospital employed or contracted personnel a physician, or a physician's representative. Representatives not escorted will be asked to leave the premises.
   d. Representatives are not allowed in any patient care areas without express permission by the Pharmacy Clinical Manager.
   e. Representatives discovered not wearing a badge, or working outside approved locations, will be asked to leave the premises. In such cases, hospital security and the Department of Pharmacy will be notified.
   f. Representatives may not access any patient specific information.
9. Drug Displays:
   a. Drug displays are promotional in nature and are discouraged. The Pharmacy Clinical Manager evaluates and advises the facility about whether displays support the mission of the facility and the care of patients. If it is determined that displays are needed, they are limited to products on the facility formulary unless the promotion of a non-formulary product has been approved.
   b. Displays, when approved, are held in an area away from patient and visitor traffic and may not restrict the passage of medical or other staff through an area.
10. Educational Programs:
   a. The topic and content of all educational programs sponsored or presented by pharmaceutical representatives must be approved by the Pharmacy Clinical Manager.
   b. This approval is required prior to scheduling the program of any materials to staff or physicians within the facility.
   c. If the educational program is approved, representatives will visit only the approved designated area as scheduled.
   d. Any pharmaceutical representative found to have distributed educational materials/information or held programs within the facility that have not been authorized by the Pharmacy Clinical Manager will be in violation of this policy and will be subject to restricted access to the facility.
11. Penalties for Pharmaceutical Representatives for Policy Deviations:
   a. Activities deemed inappropriate by the Pharmacy Department or any other department of the hospital, will result in a recommendation to the P&T Committee, MEC, and subsequently to hospital administration to bar the representative involved from visiting the facility. This ban will be in effect until lifted by written permission from an administrative officer of the hospital.

~~1.~~12. ~~GIFTS:~~Gifts:
   a. All gifts from ~~vendors~~pharmaceutical representatives, regardless of value are strictly prohibited.
   ~~b. Food provided by a pharmaceutical representative during an in-service is considered a gift and is prohibited.~~

~~i. This standard applies to events held on TCMC campus.~~

~~c. Exception to this section would include food provided in connection with a Continuing Medical Education ("CME") accredited program.~~

~~d. Textbooks and items of educational value may be provided to the institution if approved by the Department of Pharmacy and may only be give to the Department of Pharmacy for distribution to the clinical staff.~~

~~e. Free pharmaceutical samples, supplies, or equipment designated are considered a gift and are prohibited.~~

~~f. Pharmaceutical samples are not permitted at Tri-City Medical Center for personal use or for distribution to patients or family members. Distributing drug samples would place the individual in a drug dispensing role, subject to applicable laws and regulations.~~

~~i. The Department of Pharmacy may not receive or dispense any pharmaceutical samples.~~

~~ii. **Exceptions: Refer to Pharmacy Policy Drug Samples**~~

~~**D. Act**~~

~~1. All gifts from vendors, regardless of value are strictly prohibited.~~

~~a.~~**b.** Vendors may offer a hospital incentive **(i.e. discounted pricing, supplies/equipment, maintenance support) pursuant to contract agreement** if a buyer agrees to purchase the vendor's company goods or services. Personal incentives (e.g., merchandise, tickets to special events, vacation trips, etc.) are considered gifts and cannot be accepted under any circumstances.

~~b.~~**c.** Employees may not accept gifts, gratuities, or compensation in exchange for listening to a sales talk by an industry representative, for prescribing or changing a patient's prescription, or for attending a CME or non-CME activity (unless the individual is a speaker or is otherwise actively participating or presenting at the event).

~~2. Site Access by Pharmaceutical and Device Manufacturer Representatives~~

~~a. In general, industry representative may not interact with TCMC employees on campus. Interactions are allowed in limited circumstances, when the expertise of representatives is required for instruction in the use of a device and a TCMC supervisor, manager, or educator is present to supervise the interaction.~~

~~i. Under these circumstance representatives must comply with all patient care requirements and wear appropriate clothing and identification that distinguishes them from employed staff.~~

~~b. Pharmaceutical representatives may only visit the Department of Pharmacy to discuss and demonstrate their new products. While generally acceptable as straightforward sales visits, an appointment is always required.~~

~~c. Representatives are not permitted on campus on a drop-in basis.~~

~~d. Representative must use the RepTrax system and may not come onto campus if the RepTrax system alerts them to unresolved items.~~

~~e. **Pharmaceutical Vendor** Sales representatives are not permitted in any patient care areas~~

~~f. The Department of Pharmacy shall provide pharmaceutical in-services to physicians and nurses at TCMC~~

~~g. **Pharmaceutical** Sales representatives are not permitted to conduct any in-services at Tri-City Medical Center except as outlined below.~~

~~i. The in-service topic relates to a medication not adequately known by pharmacy services (such as devices and inhaled anesthetics, and radiopharmaceuticals).~~

~~ii. The industry representative providing the in-service must either be Medical Science Liaison for the product or a registered nurse or medical doctor (MD or DO only).~~

~~iii. **Purpose of visit and ducational ontent is approved by Clinical Manager in advance, per visit**~~

~~h. Pharmaceutical Vendor representatives may not access any patient specific information~~

~~3.~~**13.** Participation in Industry Sponsored Programs, Speaker's Bureaus, and Consulting:

a. Employees may accept only fair market compensation for specific, legitimate services provided by them to industry. The terms of the arrangements, services provided, and compensation must be set forth in writing and signed by both parties.

b. Employees may not accept compensation for listening to a sales presentation (e.g. detailing) by an industry representative.

c. Employees who are simply attending a CME or other instructional activity, and are not speaking or otherwise actively participating or presenting at the meeting, may not accept compensation from companies either for attending or defraying costs related to attending the meeting.

d. Employees must disclose any honorarium or payment received for all industry sources when requesting medication be added to the formulary or before presenting at Pharmacy and Therapeutics Committee meetings.

~~4.~~**14.** Industry Sponsored Scholarships and Other Educational Funds for Trainees:

a. TC**HD**~~MC~~ staff and trainees may not accept scholarships or other special funding directly from a vendor.

b. Vendors may make donations to the Education Department fund through the Foundation; the department will use its own criteria to select trainees to receive support for participation in educational events.

c. Under no circumstance can a trainee be paid by a commercial sponsor to attend an educational event where the trainee is not speaking.

d. For CME/non-CME-certified activities, reimbursement for travel, lodging, honoraria, or personal expense may not come directly from industry.

e. Exception to this rule applies only if the attendee is speaking at the event.

f. The policy is not intended to preclude industry support for staff to travel to evaluate major clinical equipment for prospective acquisition by TC**HD**~~MC~~.

~~5.~~**15.** Purchasing:

a. Staff ~~who are~~ involved in institutional decisions concerning the purchase of or approval of medications or equipment, or the negotiation of other contractual relationships with industry must not have any financial interest (e.g., equity ownership, compensated positions on advisory boards, a paid consultancy or other forms of compensation) in the vendor that might benefit from the institutional decision.

b. This provision is not intended to preclude indirect ownership, through mutual funds or other investment vehicles, of equities in publicly traded companies.

c. Staff must disclose their actual and potential conflicts of interest related to any institutional deliberations and generally may not participate in deliberations in which he or she has an actual or potential conflict of inter**est.**

E. RELATED DOCUMENT(S):

~~c.~~**1. Administrative Policy: 203 Business Visitor Visitation Requirements**

F. REFERENCE(S):

1. Pharmaceutical Research and Manufacturers of America (PhRMA). Washington D.C., January 2009. *Code on Interactions with Healthcare Professionals.*

2. CMS Conditions of Participation §482.13(c)(1)

~~6.~~**3. Health Insurance Portability and Accountability Act (HIPAA) of 1996**

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 07/03

SUBJECT: ~~AUTHORIZATION TO PERFORM (~~RESPIRATORY CARE STUDENTS~~)~~ IN THE PATIENT CARE AREAS

REVISION DATE(S):04/08, 01/10, 05/12

Department Approval:	03/17
Division of Pulmonary Approval:	04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/17
Professional Affairs Committee Approval:	07/17
Board of Directors Approval:	~~01/10,~~ 05/12

A. **AUTHORIZED TO PERFORM:**

1. All respiratory therapy students under supervision of a licensed **Tri-City Healthcare District (**TC**HD**~~MC~~**)** Respiratory Care Practitioner (RCPs).

B. **DEFINITION:**

1. Respiratory therapy students attending the residency program through ~~Concorde Career College or Pima Medical Institute for Health Sciences~~ **an accredited college for Respiratory Care** are sent to ~~area hospitals **Tri-City Medical Center**~~**TCHD** for clinical rotation experience. **It is a requirement that each school have a current contract on file in order for ~~Tri-City Medical Center~~TCHD to allow their students on site.**
   - **a.** A list of which level of rotation the students are on and written clinical objectives are sent to the pulmonary services department from the college prior to the student's arrival at the hospital.
     - ~~a.~~**i.** Example: observation only, general care, critical care, pulmonary function, pulmonary rehabilitation.
   - b. Authorization to perform: different levels of rotation and what students are authorized to complete.
     - i. Observation Only: able to follow licensed RCPs throughout the hospital in different settings to observe situations and/or procedures. No therapy may be given by the student.
     - ii. General Care: floor care, (floor care is all general respiratory care, non-critical). Examples: ~~mini-nebulizer~~**aerosol therapy**, ~~IPPB, Aerosol~~**hyperinflation therapy**, **bronchial hygiene therapy,**~~CPT/ABI vest, I.S, suctioning~~ and oxygen therapy.
     - iii. Critical Care: floor care and critical care procedures: ventilators, ~~BiPAP and CPAP~~**Non-Invasive ventilation**, intubation assist with physician and in presence of licensed RCP**, observation of ABG's**.
     - iv. Bronch/PFT: may observe and/or assist the licensed RCP in completing these procedures (PFTs, bronchoscopy, Oximetry~~-checking~~ **studies**, ~~assist with spirometry evaluations~~**Bedside Spirometry testing**, ~~pulmonary stress testing,~~ **and** patient education~~, or exercise monitoring~~..**)**
     - v. NICU: respiratory students may only observe patients in this setting.
   - c. All care provided to patients by respiratory students must be supervised by a licensed respiratory care practitioner. The **licensed** RCP will enter all charting in the hospital computer charting system.

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 05/13 **SUBJECT: PROCEDURAL TRIAGE**

REVISION DATE(S): 02/17

Department Approval:	**03/17**
Division of Pulmonary Approval:	**04/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To outline the process for the triaging ~~for~~ **of** procedures administered and performed by ~~pulmonary~~**the Pulmonary** Services clinical staff in the event of unanticipated staffing changes or increases in physician ordered procedures.

B. **POLICY:**

1. The department of Pulmonary Services will have a standardized approach for the activation of the department specific procedural triage plan.

C. **PROCEDURE:**

1. The decision for the activation of the triage plan will be at the discretion of the **Respiratory Care Practi~~c~~itioner** (RCP) ~~lead~~ **Supervisor/Charge, in consultation with the RCP Manager,** ~~assigned to that shift~~ based on their assessment of:
   a. Total house-wide respiratory care procedural volumes.
   b. House-wide patient census.
   c. Unit specific census in the adult and neonatal intensive care units.
   d. Patient acuity.
2. Verbal communication of the decision to activate the triage plan will be made to each staff member by the ~~lead~~ RCP **Supervisor/charge** assigned to that shift in order to clarify or answer any unit specific questions that staff members may have related to triage plan activation.
3. At no time will an individual clinical staff member make the decision to activate the department procedural triage plan.
4. ~~In the best interest of team collaboration, the lead RCP will consider communication with the TCMC house supervisor and house pulmonologists that the department specific procedural triage plan has been activated.~~ Clinical staff will communicate directly with the patient's assigned nurse which may be affected by the team's triage prioritization plans.
5. Re-evaluation of the need to continue with the activation of the department procedural triage plan will be every three hours or sooner based on the RCP ~~lead's~~**Supervisor/charge's** assessment and communications with clinical staff.
6. The decision to discontinue the triage plan will be at the discretion of the RCP ~~lead~~ **Supervisor/charge** assigned to that shift, based on their assignment of total house-wide respiratory care procedural volumes, house-wide patient census, unit specific census in the adult and neonatal intensive care units, patient acuity, and clinical staff skill mix.
7. **The Pulmonary manager will be kept apprised of the situation throughout the shift whenever procedural triage is initiated, re-evaluated and/or discontinued.**

D. **PROCEDURAL TRIAGE PRIORITY MATRIX ~~WILL BE AS FOLLOWS~~:**

1. In order of importance **from the care that is not triaged to the least important that may be triaged:**
   a. Any patients on continuous mechanical ventilation or non-invasive ventilation systems in adult intensive care or neonatal intensive care or emergency department units.
   ~~b. The above system assessments may be reduced to every four hours based on patient acuity.~~
   ~~c.~~**b.** Any patients on heated high flow systems or with ordered titrations.
   ~~d.~~**c.** Any inhaled medication therapy or blood draw ordered STAT, NOW, or ASAP.
   ~~e.~~**d.** Any patients ordered inhaled medications every four hours or more frequently.
   ~~f.~~**e.** Non-interventional bronchoscopy procedures.
   ~~g.~~**f.** Chest physiotherapy, including ~~Acapella~~ **Positive Expiratory pressure (PEP) therapy**~~therapy~~.
   ~~h.~~**g.** Incentive spirometer therapy.
   ~~i.~~**h.** Patients scheduled for discharge that day.

E. **REFERENCES:**

~~1. Joint Commission Standards Emergency Management and Triage (2013).~~
~~2.~~**1.** California Code of Regulations Title 22 for Staffing and Triage ~~(2007~~**2017**~~)~~.

Tri-City Medical Center	Surgical Services
PROCEDURE:	**CELL SAVER SET-UP, USE AND MONITORING**
Purpose:	To outline the steps for cell saver set-up, use, and monitoring in surgery for recovery and reinfusion of the patient's own blood.
Supportive Data:	The cell saver device is an autotransfusion system for intraoperative processing of blood lost through surgery or trauma. Blood from the surgical field is anticoagulated, collected in a sterile collection reservoir, and processed in a continuous washing process to obtain washed packed red cells for reinfusion to the patient. During this process all plasmatic and non-erythrocytic cellular components of the collected blood, and thus activated coagulation factors, products of fibrinolysis, cell trauma, and anticoagulant, are removed.
Equipment:	• **Haemonetics** Cell Saver **5+** Machine • Cell Saver Collection Reservoir • Bowl and Harness Disposable Set (125mL) • ~~Cell Saver~~**Anticoagulant** Suction **Line** ~~Tubing~~ • Yankauer Suction Tip • Transfer Packs with Viaflex Bags • Alcohol Swabs x3 • NaCl 1000mL Bag (Irrigation) • Heparin 30,000 Units • 5mL Syringe • Medication Added Label • NaCl 3000mL Bag (Wash) • 3mL Syringe with Needle • 18 gauge Needle • TUR Tubing Set • Fenwell Adapter

A. **INSTALLATION OF THE MACHINE DISPOSABLES:**

1. Power ON the Cell Saver 5+ by pressing the white ON/OFF button located on the right side of the lower cabinet. **The machine will perform a self-test. Do NOT use the machine unless it passes the self-test.**
2. **Open reservoir, load reservoir into bracket and close step-down clamp.**
3. **Attach regulated vacuum source (wall suction) to yellow-capped port on reservoir. Keep suction in the green range (-150 to -200mmHg).**

~~2.~~**4.** Open the bowl and harness disposable set **and** ~~P~~**p**lace the bowl firmly into the centrifuge well **with higher inlet port facing left**.

~~Ensure the square header on the bowl aligns with the cutout on the support arm.~~
~~Lock the support arm around the bowl header by turning the locking knob from the 8 o'clock to the 12 o'clock position.~~
~~A click will be felt or heard.~~
~~Ensure the bowl is level and spins freely.~~

~~Insert the effluent tubing into the bottom of line sensor by using a flossing motion.~~

~~3.~~**5.** Hang the waste bag on the three support pins located on the front of the machine.
   a. Ensure the drain port on the bottom of the waste bag is closed.

6. **Lock support arm around bowl header.**
   a. A click will be felt or heard.
   b. Ensure the bowl is level and spins freely.
7. **Insert effluent tubing into line sensor.**

~~4.~~**8.** ~~Place~~ **Insert** the tubing from the inlet port ~~of the bowl through the cut-out groove and through~~ **into** the air detector.

~~5.~~**9.** Open the pump platen.
   a. Thread the pump tubing around the pump **and place tubing manifold into its slots**.
   b. Close the pump platen, **manifold/valve door and latch**.

~~Place the tubing manifold in its slots.~~

Department Review	Department of Anesthesiology	Operating Room Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
05/00; 04/01; 08/01; 12/05; 09/09; 08/10; 09/12; 06/15; 11/16	n/a	12/16, 03/17	05/17	06/17	07/17	

~~Close and Lock the manifold/valve door.~~

~~6.~~**10.** Close the centrifuge and fluid deck covers.

~~7.~~**11.** Hang the reinfusion bag on the IV pole **and close small clamps on pigtails**.

~~Close the clamps on the tow tubing pigtails of the reinfusion bag.~~

a. Ensure blue line tubing clamps are open and twist-lock connection is secure.

~~8.~~**12.** Connect the red line **tubing** to the bottom of the collection reservoir **and open step-down clamp**.

~~9.~~**13.** Hang ~~the~~ wash solution (3000 ml N~~A~~a~~C~~**Cl** bag) on the IV pole.

~~Close the clamps on both yellow lines.~~

~~Spike the saline bag and open clamp to bag.~~

14. Close both yellow line tubing clamps and spike saline bag(s).

15. Open yellow line clamp(s) on saline bag(s) to be used.

~~10.~~**16.** Once the disposable set is loaded properly, press START and the system will display CURRENT SETTINGS.

a. While in CURRENT SETTINGS, the operator may press YES to restore default settings.

b. The display prompts the operator to press START to begin a procedure.

B. **COLLECTION SET-UP:**

1. Prepare the anticoagulant solution.

a. Add 30,000 Units of Heparin into 1000mL bag of 0.9% Sodium Chloride.

~~1.~~**b.** Complete the Medication Added label and attach to the heparinized saline bag.

~~2.~~**c.** Hang the ~~completed~~ **heparinized saline** bag on the IV pole located on the right of the machine.

~~Close the step-down connector clamp on the collection reservoir and place in the reservoir bracket.~~

2. Open the sterile suction line and pass it to the sterile field using aseptic technique.

3. Connect the suction tubing to the yellow port of the reservoir and to the ~~Neptune or suction source~~**regulated wall suction, and turn ON suction. Do NOT use Neptune as suction source for Cell Saver machine.**

~~Turn on the Neptune or suction source. Regulate suction to a minimal acceptable flow rate, under 200 mmHg.~~

a. Regulate suction to keep between -150 and -200mmHg.

~~a.~~**b.** Vacuum levels greater than -200mmHg may cause hemolysis.

4. Receive suction line from the sterile field~~.~~ **and attach to blue-capped port on collection reservoir.**

~~Attach the blue-capped end to a blue port on the collection reservoir.~~

5. Spike the heparinized saline bag.

6. Prime the collection reservoir with 200mL of ~~anticoagulant~~ **heparinized saline**.

a. Regulate the anticoagulant drip rate to approximately one drop per second.

~~Set the drip rate to approximately a 1:7 anticoagulant to salvaged blood ratio, or approximately 15mL of heparinized saline to 100ml of salvaged blood.~~

~~Once the disposable set is loaded properly, press START and the system will display CURRENT SETTINGS.~~

~~While in CURRENT SETTINGS, the operator may press YES to restore default settings.~~

~~The display prompts the operator to press START to begin a procedure.~~

C. **COLLECT FIRST OPTION:**

1. Use the collect first method if it is not clear that sufficient volume will be collected during a procedure to process for reinfusion.

2. Set up the machine for collect first:

a. Load collection reservoir into bracket and close step-down clamp.

b. Attach regulated vacuum source to yellow-capped port on reservoir.

c. **Receive sterile suction line(s) from the field and attach to blue-capped port(s) on reservoir.**
d. **Prepare, hang and spike heparinized saline solution (as described in B.1)**
e. **Prime reservoir with 200mL heparinized saline solution, then adjust drip rate of heparinized saline to 1 drop/second.**

3. **Load Cell Saver 5+ processing set if sufficient blood volume is collected.**

~~**MODIFY PARAMETERS IN AUTOMATIC MODE**~~

~~Press MODIFY~~
~~SELECT parameter you wish to be modified~~
~~Press YES to increase value and NO to decrease value.~~
~~Press MODIFY when finished.~~

~~**MODIFY PARAMETERS IN MANUAL MODE**~~

~~The operator must initiate all processing mode changes.~~
~~The machine displays the following modifiable parameter available in the Manual mode.~~

~~FILL Rate~~	~~500mL/min~~
~~WASH Rate~~	~~500mL/min~~
~~EMPTY Rate~~	~~500mL/min~~
~~Centrifuge Speed~~	~~5650 RPM~~
~~Waste Bag Weigher~~	~~ON~~
~~ALARM Sound~~	~~ON~~

~~Press ARROW keys to change values.~~
~~Press SELECT to advance highlight.~~
~~Press MODIFY when finished.~~

~~C.~~D. PROCESSING IN AUTOMATIC MODE:

1. The FILL mode automatically begins when the preset reservoir level is reached.
   a. To begin processing prior to reaching this preset fluid level, press START.
   b. The Cell Saver 5 automatically advances through the FILL, WASH, and EMPTY modes if enough salvaged blood and wash solution are available.
2. The machine automatically advances to the WASH mode when the RBC's reach the optics trip point, ¼ inch over the shoulder of the Latham bowl.
3. If there is an insufficient volume of blood collected for the RBC's to reach the trip point, the air detector senses air from the red line and the system enters the STANDBY mode.
   a. The machine automatically resumes the FILL mode when the "Resume At" Level has been reached.
4. In the WASH mode, the programmed minimum volume of wash solution is pumped into the bowl to dilute the supernatant contaminants with the RBC's.
5. The EMPTY mode stops the spinning of the centrifuge.
   a. The contents of the bowl are pumped through the blue line to the reinfusion bag.
6. The CONC mode is commonly used at the end of a procedure when no more blood loss is expected and there are not enough red blood cells to fill the bowl.
   a. In this mode, red cells in the reinfusion bag are pumped to the bowl.
7. The RETURN mode pumps the bowl contents to the reservoir.

E. QUALITY CONTROL:

1. **Test Hematocrit on first bowl of processed blood prior to administration ~~to~~ for ~~monitor~~ Quality Control monitoring. ~~.~~**

~~PROCESSING IN MANUAL MODE~~

~~When Manual mode is selected the operator must advance the system from one mode to the next (FILL, WASH, EMPTY, CONCENTRATE, RETURN)~~

~~The operator is responsible for ensuring that the effluent line appears clear and colorless at the end of the WASH mode.~~

~~If the effluent line appears red-tinged and extended wash procedure must be performed.~~

~~The transfusion of inadequately washed RBC's could result in adverse reaction in the recipient.~~

~~D.~~F. EMERGENCY MODE:

1. The EMERGENCY **mode may be used when the reservoir is filling too fast due to rapid blood loss and it is necessary to process blood urgently for immediate transfusion** ~~option is available for those situations in which the speed at which blood is available for return to the patient is the most important factor~~.
2. The EMERGENCY ~~option~~ **mode** will process blood solution continuously through the FILL, WASH, and EMPTY modes until ~~the air detector senses air in the FILL mode~~ **no more RBC's remain in the reservoir**.
   a. When the reservoir is empty ~~and the air detector senses air~~, the Cell Saver 5**+** will automatically ~~switch back~~ **return** to ~~the~~ Automatic mode.
   b. The operator may also choose to ~~CONC~~**Concentrate** or RETURN cells to reservoir while in the EMERGENCY ~~option~~ **mode**.
3. Red cells may ~~be lost~~**spill** into the waste bag as a result of choosing the EMERGENCY option, due to the increased pump rate.
4. To enter EMERGENCY option:
   a. Press the MODE key ~~once~~ **twice within two seconds**.
   b. ~~The operator will then be prompted to confirm this choice by p~~**P**ress~~ing~~ the YES key within 5 seconds **to confirm**.
   c. If the YES key is not pressed within 5 seconds, or the NO key is pressed, the Cell Saver 5**+** will revert back to the ~~Manual~~ **Automatic** ~~M~~**m**ode.
5. To exit EMERGENCY ~~option~~ **mode** and return to Automatic mode, press the MODE key once.

~~E.~~G. PARTIAL BOWL OPTIONS~~:~~

1. **Use partial bowl option to process a partial bowl of blood at the end of a procedure or whenever it is necessary to process blood before a full bowl has been collected.**

~~1.~~**2.** To process a partial bowl:
   a. Press WASH to begin **partial bowl** wash~~.ing.~~
   b. Double the ~~minimum wash volume~~ **programmed wash volume by pressing the YES key to automatically double the programmed wash volume for that wash cycle only.**

~~b.~~**c.** **Blood processed in a partial bowl cycle may have a lower hematocrit than blood processed in a normal full bowl cycle.**

~~2.~~**3.** To concentrate RBC's:
   a. If RBC's in reinfusion bag, press CONC to fill bowl.
   b. Wash with minimum wash volume.

~~F.~~H. EMPTY THE BLUE LINE:

1. **At the completion of the procedure, approximately 40mL of RBC's remain in the blue line that should be emptied to the reinfusion bag.**
2. **Do not empty the blue line during the procedure or the bowl displacement air will be lost adversely affecting subsequent EMPTY modes.**

~~1.~~**3.** To empty 40mL remaining in the blue tubing into the reinfusion bag:
   a. DONE AT END OF CASE ONLY **for last bowl processed**!

b. Press START, then press EMPTY, and repeat (Press START then EMPTY) until the blue striped line is empty.

c. Alternatively, **when the EMPTY mode is complete and prior to entering STANDBY a message will flash for 10 seconds "Is Case Completed? Y/N". If the NO key is pressed or no action is taken within 10 seconds, the machine will enter STANDBY. If the YES key is pressed within 10 seconds, the following message will flash: "Empty Blue Line? Y/N". If the YES key is pressed, the machine will empty the line at 100mL/min and then enter STANDBY. If the NO key is pressed, the machine will enter STANDBY without emptying the line.** ~~press MODE to enter Manual mode then press EMPTY (repeat pressing EMPTY until blue line is empty).~~

~~G.~~I. EMPTY AND CHANGE THE WASTE BAG:

1. **When emptying/changing the waste bag, do not lose the displacement air from the system. If this occurs, the bowl may not empty properly.**

~~1.~~2. ~~Ensure that the waste bag is completely emptied~~**Empty the waste bag by draining waste fluid into an empty container for discard or use an extra suction line to suction out the waste bag.**~~:~~

a. ~~Drain waste fluid into empty irrigation bottles or use extra suction line to Neptune or suction source~~**DO NOT completely empty the waste bag. Unless the bowl is completely empty, keep fluid level in the waste bag ABOVE the drain port, to prevent loss of displaced air.**

~~2.~~3. Change the waste bag at the end of the EMPTY mode, only when the machine is at rest **to prevent the loss of displacement air**.

a. Prior to removing the full waste bag, ~~P~~press STOP to ensure that processing does not begin.

~~a.~~**b. When the new bag is installed press START to resume.**

~~H.~~J. DOCUMENTATION:

1. ~~The following information is documented in~~**Document the following information in** the Cell Saver segment of the Perioperative Nursing Record:

a. Cell Saver operator's name
b. Cell Saver machine identification number
c. Type and amount of anticoagulant used
d. Volume collected in reservoir
e. Volume returned to patient
f. Wash volume
g. Hematocrit of first processed unit ~~blood~~ (QC)
h. Name of person reinfusing blood

~~Processed Volume~~
~~Wash Volume~~
~~Reinfusion volume~~
~~Type and amount of anticoagulant~~
~~Names of the individuals performing the blood collection and processing~~
~~Quality of the effluent line's contents after WASH mode is completed~~

~~a.~~**i.** Comment section to document any complications and/or adverse reactions during the procedure

~~I.~~K. BREAKDOWN AND CLEANING:

1. Power the machine OFF.
2. Close all clamps on the disposable tubing.
3. Cap all open ports **on the collection reservoir**.

a. ~~Extra step-down connectors for the suction line~~ **Tubing stubs and caps included with the reservoir and processing kit** may be used for closing open ports.

4. Remove the waste bag from support pins **(may be emptied before removing)**.
5. Remove the bowl from the centrifuge well.
6. Remove the remaining tubing harness.
7. Remove the collection reservoir; **keep tubing harness connected to reservoir outlet to avoid fluid spill**.
8. Place the machine disposables in a biohazardous waste bag.
9. Wipe the exterior of the machine ~~with~~ **with a cloth moistened with hospital-approved** disinfectant.

~~1.~~**a. Do not spray or pour disinfectant solution on machine.**

~~J.~~L. MACHINE PREPARATION :

1. Prepare machine for next case or emergency use:
   a. Ensure machine is clean.
   b. Replace all disposables.
   ~~c.~~**c.** Restock supplies on bottom shelf of machine.

M. REFERENCE(S):

~~2.~~1. **Haemonetics Cell Saver 5+ System Operator's Manual**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES

SUBJECT: **VISITORS IN THE OR**

ISSUE DATE: **04/94**
REVISION DATE(S): 02/05, 06/09, 10/12, 04/15, 09/16

Department Approval:	**03/17**
Operating Room Committee Approval:	**03/17**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To assure that the patient, Health Care Team, and Perioperative Services are notified and/or given permission for a non-medical person to observe a surgical procedure.

B. **DEFINITION(S):**
1. Non-**Medical** ~~**Clinical** medical personnel~~ **observer**: those who have no clinical or scientific affiliation with Tri-City Medical Center **(TCMC)**, the surgical procedure, or the medical and scientific equipment being used.
2. **Medical observer: those who have no clinical or scientific affiliation with TCMC, the surgical procedure, or the medical and scientific equipment being used, however, do have a current valid license in a patient care field, such as a Medical Doctor (MD), Registered Nurse (RN), and Physical Therapist (PT).**
~~2.~~**3.** Exemptions from this policy: Medical and Nursing personnel and students and related health care workers who are affiliated with TCMC.

C. **POLICY:**
~~All observers must be cleared through the Education Department (x3100) before the day of observation in surgery.~~
1. **The request for an observer must be communicated to the Perioperative Director prior to the day of surgery by the sponsoring physician.**
2. **Medical and Non-Medical observers have a maximum of five (5) observation opportunities during a 30 calendar day period.**
3. Non-**Medical**~~**Clinical** Medical Personnel~~ **observers**:
   - **a. Must be at least 18 years of age.**
   - ~~a.~~**b.** The surgeon, anesthesiologist, Charge Nurse, and the patient must consent that the named person be allowed to observe the procedure(s).
   - ~~b.~~**c.** The Operating Room must be notified prior to surgery that the named person has permission to observe a specific procedure(s).
   - ~~c.~~**d.** ~~An Operating Room Observer~~ **A Consent for Observer in Surgical Procedures** ~~F~~form shall be ~~properly~~ completed and in the patient's chart prior to the patient coming to the Operating Room.
   - ~~d.~~**e.** Family members and/or significant others of the patient may not observe surgical procedures. ~~Children having surgery may be carried into the OR by their parents.~~
   - ~~e.~~**f.** Limit of one observer per room will be allowed to provide for patient confidentiality, **to** maintain the sterile field, and to control traffic in the Operating Room. Special exceptions will be evaluated on an individual basis.

g. Observers are not allowed to **enter the operating room before the patient is fully positioned, prepped and draped for surgery. Special exceptions will be evaluated on an individual basis.**

~~f.~~**h.** **Observers are not allowed to** touch the patient, "scrub in" or participate in the care of the patient.

~~2.~~**4.** Medical Personnel:

a. Medical personnel who wish to observe must have approval of the surgeon, anesthesiologist, and the Director of Surgery (or Assistant Nurse Manager/Charge Nurse).

~~b. Sales representatives are allowed to observe a case if their presence relates to a product being used during the time the product is in use.~~

D. **PROCEDURE:**

1. Observers shall report to the Operating Room desk at specified time and state their name, title, and purpose. A name tag will be provided to identify the observer and must be worn at all times.
2. Observers shall don surgical attire in the appropriate Surgery locker room, in accordance with Patient Care Service Policy: Surgical Attire.
3. All valuables shall be placed in the assigned locker and other valuables may be taken to the OR Desk for safekeeping.

~~3.~~**a.** Note: Valuables shall not be left in the Locker Room unless in a locked locker.

4. A staff member shall escort the observer to the appropriate room and instruct them in the appropriate use of the mask.
5. A staff member shall introduce the observer to the room personnel and explain appropriate conversation etiquette.
6. The observer shall stand/sit out of the traffic pattern until the circulator can assist in moving him/her to the point of observation.
7. Observers shall ask questions as needed during an appropriate time.
8. Observers shall ask the circulator for assistance if the need arises to move about the room.
9. While moving around the room, proper aseptic technique must be maintained by keeping at least a minimum of 12" distance between non-sterile personnel and any sterile item or person.
10. Observers shall report directly to the Main Desk when leaving the assigned room.
11. Observers shall not enter **or exit** any **operating** room without an escort.

E. **RELATED DOCUMENT(S):**

~~11.~~**1. Administrative Policy: 203 Business Visitor Visitation Requirements**

Tri-City Medical Center
Oceanside, California

Women and Newborn Services (WNS)

SUBJECT: INFANT TRANSPORT INTRA-FACILITY

ISSUE DATE: 06/14
REVISION DATE(S):

Department Approval:	**01/17**
Department of Pediatrics Approval:	**~~05/13~~05/17**
Department of OB/GYN Approval:	**~~06/13~~06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**~~06/14~~07/17**
Board of Directors Approval:	**06/14**

A. **PURPOSE:**
1. To outline the policy for infant transport within the medical facility.

B. **POLICY:**
1. Special attention is required when transporting infants from one area of the hospital to another due to potential infection control and infant abduction concerns. This policy is intended to provide a standard procedure which ensures that all infants are transferred safely.
2. Infants transported within the departments of Women and Newborn Services (WNS) which consists of (Labor and Delivery, Mother Baby Unit (MBU), MBU South, Nursery) will be escorted by a staff member. It is beneficial if the staff member is certified as a Neonatal Resuscitation Provider (NRP).
3. An infant who needs to be transported intra-facility (ex: radiology) will be escorted by **an assigned staff member.** ~~nurse who is certified in NRP.~~
4. In support of a patient and family centered care culture, parents/family members wearing the infant identification band are invited to accompany the infant when transported.
5. In emergent situations, infant shall be transported in an open crib to the treatment area while lifesaving measures are initiated, as appropriate, and per WNS standardized procedure: Code **Caleb**~~Pink in Women and Newborn Services~~.

C. **DEFINITION(S):**
1. Intra-facility (internal transfer: Infants transferred from one area of the hospital to another area.
2. Transfer of a Neonate/Infant to the morgue: See the **Miscarriages and Stillbirth Identification and** ~~policy in the patient care services manual: Deceased Patient Care and~~ Disposition **procedure.**

D. **MODE OF TRANSFER:**
1. All infants less than or equal to 32 weeks gestational age and/or less than 1500 grams will be transported in an incubator. (Please see Very Low Birth Weight Thermoregulation procedure and Transfer of Neonates and Infants policy).
2. All infants requiring oxygen and/or who are hemodynamically unstable will be transported in an incubator. (See Transfer of Neonates and Infants policy).
3. Infants who are thermodynamically and hemodynamically stable with normal vital signs, will be transferred in an open crib based on the **nurse**~~RN~~'s evaluation of **the** patient's safety needs.
   a. Infants with expected admissions to the Neonatal Intensive Care Unit (NICU) shall be transferred with a pulse ox (oxygen saturation monitor) in place.

E. **DURING TRANSFER:**

1. When the infant is ready for transfer, the primary nurse will provide report to the receiving nurse utilizing the appropriate hand-off communication or off unit/transfer ~~assessment ad hoc~~ form.
   a. If the infant is being transported to another area other **than in** the WNS for a procedure, **a staff member** ~~the nurse~~ will remain with the infant the entire time. ~~(This includes procedures performed in the NICU).~~
   ~~b. An infant resuscitation transport bag will accompany any infant being transported intra-facility outside the WNS departments.~~
   ~~c.~~**b.** Identification bands on the infant shall be compared to the parent/caregiver, banded person before transfer and upon return.
2. The infant will wear a hat, be swaddled in two blankets and be placed in supine position in an open crib in the flat position for traveling. A bulb syringe will be place at the foot of the crib.
3. Transport personnel shall be trained in Basic Life Support (BLS) and/or be a Neonatal Resuscitation Provider (NRP), as appropriate.
   ~~a. Infants transported outside (WNS) require an RN who is NRP certified.~~
4. At a minimum, vital signs (including temperature) and a brief assessment shall occur before leaving the area and upon return to the sending area. The infant should have direct line observation during the transport in the open crib or transporter.

F. **AT DISCHARGE:**

1. Infants discharged from Tri-City Medical Center shall be accompanied by a banded and/or properly identified parent/caregiver AND a staff member/volunteer, to the designated hospital entrance.
2. Infants ~~are~~**shall- be** transported off the unit in the arms of the mother/caregiver, **who is** seated in a wheelchair.

G. **REFERENCES:**

1. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, 7th Ed. Washington, DC: ACOG; 2012; Elk Grove Village, IL: AAP; 2012.

Tri-City Medical Center
Oceanside, California

WOMEN'~~S~~ AND NEWBORN'~~S~~ SERVICES

STANDARDS OF CARE – INTRAPARTUM

I. **PREAMBLE:**

A. Nursing practice in the care of Women's and Newborn's **Services (WNS)** is delivered in an environment that respects the goals, preferences, and patient rights of ~~the unique dyad of the maternal-fetal unit and/or mother-baby couplet and~~ the family from admission, through the episode of care, to discharge. The **WNS** ~~Women's~~ and ~~Children's~~ nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN). ~~Couplet-care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices.~~

II. **DEFINITION(S):**

A. Standards of Care: "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable (ANA p. 77)". "Standards of care describe**s** a competent level of nursing care as demonstrated by the nursing process (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.

B. Scope of Nursing Practice: "D~~d~~escribes the who, what, where, when, why, and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010~~)~~. "~~"~~.

C. Standards: "Authorative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2010, p. 67).

~~A.~~**1. "Standards of care are Standards of Professional Nursing Practice."**

~~A.~~**D.** Nursing Process: **"The essential core of practice for the Registered Nurse (RN) is to deliver holistic, patient-focused care.** ~~Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision-making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to the woman and for her fetus or newborn, caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care.~~ The nursing process **as outlined by the ANA (2016)** includes the following:

~~1.~~**E.** Assessment: A systematic, dynamic **way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors.~~"~~. An assessment includes subjective and objective data.** ~~process by which the registered nurse, through interaction with the patient, significant others, and health care providers, collects comprehensive data with the priority of data collection determined by the immediate condition of the woman, the fetus or newborn and their needs for health promotion, maintenance and restoration.~~

~~a. Registered Nurses (RN) perform assessments.~~

~~b. Obstetrical Technicians (OB Techs) and OB Advanced Care Technicians (ACTs) collect patient data.~~

Department Review	Department of OB/GYN	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
04/13, 11/16	**06/17**	n/a	**06/17**	06/14, **07/17**	06/14

~~c. Only RNs perform admission, transfer, and and/ or discharge assessments.~~

1. **Subjective-what the patient says.**
2. **Objective-observation based on assessment findings.**

~~2.~~**F.** Diagnosis: A **nurses's** clinical judgment about the client's response to actual or potential health conditions or needs.

~~3.~~**G.** Outcomes/**Planning**: **"Based on the assessment and diagnosis. Outcomes are m**~~M~~easurable **and achievable short and long-range goals."**~~., expected, client-focused goals~~

~~2.~~**H.** Planning: ~~(~~**Care Plan i.e.** Plan of Care~~)~~: A comprehensive outline of care to be delivered to attain expected outcomes.

~~4.~~**I.** Implementation: **"Nursing care is implemented to the care plan. This is "continuity of care" from the patient during hospitalization and in preparation for discharge needs."**~~. Includes any or all of these activities: intervening, delegating, and/or coordinating the plan of care.~~

~~3. TCMC's, Mosby's, and Unit Specific Procedures shall be used to implement nursing interventions when appropriate.~~

~~5.~~**J.** Evaluation: The process of determining both the **"patient's status and the effectiveness of nursing care. It is a process that involves continuously~~ evaluation of the patient and the modifications to the Plan of Care."~~.** ~~client's progress toward the attainment of expected outcomes and the effectiveness of nursing care.~~

~~B.~~**K.** Patient: Recipient of nursing care.

~~C.~~**L.** Health Care Providers: Individuals with special expertise who provide health care services or assistance to clients

~~D.~~**M.** Significant Others: Family members and/or those significant to the client.

~~E.~~**N.** Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.

~~F.~~**O.** "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010).~~"~~.

II. ~~WCS~~WNS STANDARDS OF PRACTICE:

A. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
B. A comprehensive and dynamic data-base shall be maintained on all patients admitted to the hospital.
C. The patient can expect to have appropriate confidentiality maintained at all times.
D. The patient can expect that the RN shall ensure the optimal desired level of privacy.
E. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
F. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
G. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
H. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
I. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
J. An appropriate plan of care shall be formulated for each patient.
K. The plan of care will be implemented according **to** the priority of identified problems or needs.

L. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.

M. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

III. **NURSING PROCESS:**

A. STANDARDS OF CARE: ASSESSMENT

1. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.

B. **STANDARDS OF CARE: DIAGNOSIS**

1. RN shall review the data obtained from each patient's assessment, history, and ~~i~~information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.

C. STANDARDS OF CARE: OUTCOME IDENTIFICATION

1. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.

D. STANDARDS OF CARE: PLANNING

1. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.

E. STANDARDS OF CARE: IMPLEMENTATION

1. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task**s** appropriately.

F. STANDARDS OF CARE: EVALUATION

1. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCM**C** ~~C~~ policy.
2. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
3. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.

G. STANDARDS OF CARE: DOCUMENTATION

1. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided **will** be documented after completion of the care in a timely manner.
2. When it is not possible to document ~~shift assessments, reassessments, PRN assessments and/or care provided~~ due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.
~~2.~~**3.** Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

IV. **GENERAL OB NURSING ASSESSMENT**

~~I.~~**A. STANDARDS OF CARE: VITAL SIGNS**

1. Maternal vital signs shall include:

a. Temperature, documented in Celsius (preferred)
b. Heart Rate (HR)/ Pulse
c. Blood Pressure (BP)
d. Respiratory Rate (RR)
e. Oxygenation/ SpO2, as indicated
~~A.~~**f. Pain level**

1.2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge (if discharged home undelivered) per Patient Care Services (PCS) procedure Discharge of Patients, per provider's orders, and **may be modified** as **follows:**follows:

B. Maternal vital signs shall include:
1. Temperature, documented in Celsius (preferred)
2. Blood Pressure (BP)
3. Heart Rate (HR)
4. Respiratory Rate (RR)
5. SpO2
C. Pain Level

2.3. Intrapartum:

a. Hourly blood pressure, pulse and respirations**, when in labor.**

1.**i.** levery 30 minutes if patient has an oxytocin or epidural infusion**, vital signs may be q 15-30 minutes per provider orders.**

2.**ii.** **C**ontinuous pulse oximetry **may be needed,** once epidural **is** placed and/or with magnesium sulfate administration per procedure **and provider order**) or more frequent**ly per patient condition.** per epidural or magnesium sulfate procedure

3.**b.** Maternal temperature every 4 hours **or per provider orders and usually,** every 2 hours if membranes are ruptured**, and** or every hour if febrile.

a. Notify provider if:
i. Temperature greater than or equal to 100.4° F or 38° C
ii. Blood pressure greater than or equal to systolic 140 or less than 90
and/or diastolic 90 or less than or equal to 50; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
iii. Pulse greater than or equal to 120 bpm
4. Respirations greater than 28 or less than 10

c. Fetal Monitoring per Fetal Heart Rate Surveillance Procedure, induction procedure/policy or as ordered per provider

c.**d.** **Immediate Postpartum/ Recovery after a** Postpartum, Vaginal Delivery:

e. Vital signs: **Pulse, BP, and RR**, including temperature, every 15 minutes x4, **q 2 hr x 1, then q 6 hours**at 2 hours **for the first 24 hours,**, upon admission to couplet care, then every 6 hours for the first 24 hours post delivery, then every shift until discharge and prn as clinically indicated

5.**f.** **Temperature shall be taken once during recovery and more frequently if febrile.**

6. Notify provider if:
a. Temperature greater than or equal to 100.4° F or 38° C
b. Blood pressure greater than or equal to systolic 140 and/or diastolic 90 greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
c. Pulse greater than or equal to 120 bpm
d. Respirations greater than 28 or less than 12

D.**g.** **Immediate Postpartum/ Recovery** Post-Operative, Cesarean Delivery:

i. **Recovery**PACU vital signs as ordered by anesthesiologist**, and Medical system for measure of recover after anesthesia, Activity, RR, Color, Blood Circulation, consciousness usually Pulse, BP and RR every 5 minutes x3, then q 15 until a Modified Aldrete score of 8/10 or greater is achieved.** /provider

ii. **Pt shall be placed on Cardiac Monitor during recovery and have EKG rhythm strip printed x1 and placed in the medical record for capture validation.**

~~1.~~iii. **Temperature shall be taken once during recovery and more frequently if febrile.**

~~2. Vital signs, including temperature, upon admission to couplet care, at 2 hours~~
~~a. then every 6 hours for first 48 hours post delivery, then every shift and prn as clinically indicated~~

~~3.~~**h.** Notify provider if:
- i. Temperature greater than or equal to 100.4° F or 38° C
- ii. Blood pressure greater than or equal to systolic 140 **systolic** and/or **greater than or equal to 90** diastol**ic.** ~~ic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic~~
- iii. Pulse greater than or equal to 120 bpm
- iv. Respirations greater than 28 or less than 12

B. STANDARDS OF CARE: PAIN ASSESSMENT

1. Assessment: Pain per Pain Management Policy
   - a. A general pain assessment shall consist of the following:
     - ~~4.~~i. Acceptable level of pain intensity
     - ~~5.~~ii. Pain scale
     - ~~6.~~iii. Current pain intensity
   - ~~a.~~**b.** If patient complains of pain, assess the following:
     - i. Location, intensity, and duration/onset
     - ii. Quality/type
     - iii. Aggravating factors
     - iv. Alleviating factors
2. Assess for presence of pain/discomfort with vital signs and PRN
3. Perform a pain assessment with each patient report of new or different pain.
4. Perform a pain reassessment as follows:
   - a. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous ~~i~~Intervention
   - b. One (1) hour after PO intervention

C. STANDARDS OF CARE: INTAKE AND OUTPUT

1. Intake and output shall be monitored as ordered and as follows:
   - a. Intrapartum:
     - i. I&O totals every shift with 24 hour totals
     - ii. Assess bladder ~~every~~ ~~2 hours while awake,~~ every 4-6 hours ~~when sleeping~~, or as ordered by provider
     - iii. Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour, or less than or equal to 120 mL in 4 hours.
     - iv. Bleeding
       1) Patients shall be screened for risk of obstetrical hemorrhage upon admission, and as part of the ongoing reassessment throughout antepartum and/or intrapartum admission.
       2) Patients will be screened who present to labor and delivery with placenta previa, accreta and its variants, possible placental abruption with or without vaginal bleeding
          - a) Assess and document quantity (# of pads/chux, degree of saturation and/or weigh as needed.), color, associated symptoms and frequency of bleeding
          - b) Notify provider ~~offer~~ active bleeding, and report above findings.
          - c) Refer to ~~WCS~~**WNS** procedure: Obstetrical Hemorrhage.

D. STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS

1. Height and weight can be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation allows, it is preferred that the patient be weighed upon admission.
   a. Weights shall be documented in kilograms (kg) and height in centimeters (cm).
2. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.

E. STANDARDS OF CARE: ASPIRATION ASSESSMENT

1. Maintain aspiration precautions for maternal patients identified at risk.
   a. Maintain head of bead (HOB) at 30 degrees at all times.
   b. If eclamptic seizure **occurs**, lower head of bed, open airway, roll patient to side and suction secretions as necessary.
      i. Avoid attempts to insert suctioning device when patient's teeth are clenched.
   c. Maintain suction equipment at bedside at all times.

F. STANDARDS OF CARE: PATIENT SAFETY

1. The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes having the bed in the lowest position, wheels locked, and room free of clutter

2. Patient safety shall be assessed per the following:
   a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures, and as needed.
   b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
   c. Allergies will be monitored and documented upon admission.
      i. Any known medication or food allergy shall be documented as follows:
         1) The patient allergy band
         2) Allergy sticker placed on the front of the chart
         3) **In patient's Electronic Medical Record (EMR)** ~~Medication Administration Record~~
   d. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders Policy.
   e. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
   f. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
   g. Electronic or medical equipment brought to TCMC shall be evaluated, used, a**nd** stored per PCS: Medical Equipment Brought into the Facility Policy.
   h. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
   i. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.
   j. Medication shall be reconciled per PCS: Medication Reconciliation Policy.
   k. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

VI. SYSTEM REVIEW

A. All maternal patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

B. STANDARD OF CARE I: ASSESSMENT

1. All patients admitted to ~~WCS~~**WNS** nursing units shall be assessed by a Registered Nurse per the following:
2. Admission and/or Transfer: Assessment

a. All patients admitted or transferred to a higher level of care shall have a focused assessment initiated ~~within 15 minutes~~**as soon as possible** ~~upon 3 hours of arrival to unit~~. A detailed or disease specific assessment shall be document as needed.
b. The assessment shall be completed in a timely manner dependent on the situation (stage of labor or urgency in which the patient is being seen).

3. Admission Assessment- Patient History:
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
      i. This assessment-patient history shall include an assessment for obstetric hemorrhage.
4. Medication Patient History Form
   a. All patients shall have a Medication Patient History completed ~~as soon as possible~~ upon arrival to the unit per the Medication Reconciliation Policy.
5. Initial Shift Assessment
   a. An RN shall initiate an ongoing head to toe assessment **at the beginning of the shift.** ~~as follows: within 1-3 hours of the start of the shift~~
6. Reassessment
   a. After completion of an Admission ~~or an~~/ Initial shift **a**~~A~~ssessment patients are reassessed prn **and** as clinically indicated.
   ~~a. Guidelines for reassessment are as follows:~~
      ~~i. Admission or Initial assessment q shift or prn as clinically indicated~~
      i. If the patient refuses a reassessment, document ~~their~~ refusal in the medical record.
   b. System Specific/ **Focus** ~~Assessment (Focus~~ assessment/~~postpartum assessment)~~ shall be completed as follows:
      i. **When there is a c**~~C~~hange in patient's condition **and when clinically indicated.** ~~from Admission assessment or initial shift assessment.~~
      ii. **In r**~~R~~esponse to **a** treatment **given**~~provided~~ to patient.

C. STANDARDS OF CARE 1.1: ASSESSMENT NEUROLOGICAL SYSTEM REVIEW

1. Neurological: System Review
   a. Assess the following on admission, transfer of care, once a shift unless otherwise indicated more frequently (i.e. ~~WCS~~**WNS** procedure Magnesium Sulfate):
      ~~2.~~**i.** Level of consciousness
      ~~3.~~**ii.** Orientation
      ~~4.~~**iii.** Presence of:
         ~~a.~~**1)** Headache
         ~~b.~~**2)** Visual disturbances, e.g. blurred vision or scotoma
      ~~5.~~**iv.** Deep Tendon Reflexes
      ~~i.~~**v.** Patellar or brachial
      ~~ii.~~**vi.** Clonus
      ~~6.~~**vii.** Effects of epidural/regional anesthesia on lower extremities
         ~~a.~~**1)** Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
         ~~b.~~**2)** Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: ~~WCS~~**WNS** procedure: "Epidural Medication Administration").

D. STANDARDS OF CARE 1.2: ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW

1. Cardiovascular System Review
   a. Assess heart sounds ~~in all auscultatory areas~~; note regular or irregular **rhythm.**
   b. Check capillary refill
   c. Check edema location and grade
   ~~c. Palpate bilateral peripheral pulses: radial and dorsalis pedis~~
   d. Assess peripheral perfusion; skin warm and dry

e. Assess Homan's sign for presence of thrombophlebitis.

E. STANDARDS OF CARE 1.3: ASSESSMENT PULMONARY SYSTEM REVIEW

1. Pulmonary: System Review
   a. Check oxygen delivery devices if applicable
   b. Check amount oxygen flow if applicable
   c. Assess **of** pulse oximetry **as indicated**
      i. Continuous monitoring post-epidural placement
      ii. Per orders or per PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"
   d. Assess respiratory effort
   e. Auscultate breath sounds all lobes
   f. Assess sputum amount, color, and consistency if applicable
   g. Assess for presence of cough
   h. Assess for presence of artificial airway, tubes, and drains if applicable.
   i. Assess chest expansion for symmetry

F. STANDARDS OF CARE1.4: ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW

1. GI: System Review
   a. Assess gravid abdomen:
      i. Round, gravid, distention.
      ii. Soft, firm, distended, non-distended.
      ~~ii.~~**iii. Pain upon palpation, right upper quadrant pain.**
   b. Assess for nausea and/or vomiting.
   c. Auscultate for presence of bowel sounds in all four quadrants.
   d. Assess bowel function including passing flatus or last stool.

G. STANDARDS OF CARE 1.5: ASSESSMENT GENITOUTINARY SYSTEM REVIEW

1. Genitourinary (GU) System Review
   a. Assess urine color and clarity, frequency and dysuria.
   b. Assess for bladder distension.
      ~~d.~~**i.** Assess external anatomy/perineum as applicable~~Assess risk for obstetric hemorrhage~~
      ~~i.~~**ii.** Assess for leaking of amniotic fluid :~~(if applicable)~~
         1) Color, amount, and/or odor.
      ~~ii.~~**iii.** Assess vaginal discharge:~~, if applicable.~~
         ~~i.~~**1)** Color, amount, and/or ~~odor~~**odor.**

H. STANDARDS OF CARE 1.6: ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW

1. Musculoskeletal System Review
   a. Presence of assistive devices.
   b. Presence of joint or musculoskeletal abnormalities.
   c. Full range of motion against gravity, some to full resistance of all extremities.
   d. Mobility appropriate for age.

I. STANDARDS OF CARE 1.7: ASSESSMENT INTEGUMENTARY SYSTEM REVIEW

1. Integumentary System Review, Maternal:
   a. Assess mucous membranes and skin color; consistent with person's ethnicity.
   b. Palpate skin for temperature and moisture.
   c. Assess skin turgor.
   d. Assess skin integrity, temperature, and condition of any dressings.
   e. Complete Braden Scale**- Prediciting bed sore risk.**~~.~~
   f. Assess for presence of specialty mattress/bed or overlays.
   g. ~~.~~Assess for the presence of skin abnormalities.
   h. Assess for the presence of pressure ulcers.

J. STANDARDS OF CARE 1.8: ASSESSMENT PSYCHO/SOCIAL

1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior

c. Social Service (SS) Referral Reason
d. Distress
e. Stressors
f. Support/Coping Interventions

2. Psycho/Social: Nursing Interventions
   a. In ordered to promote family centered care, the nurse shall:
      i. Introduce bedside health care providers to the patient/family.
      ii. Review visitation and unit policies to patient/family on admission and as needed.
      iii. Assess and then verify with patient/family age appropriate needs.
      iv. Assess and then verify patient/family's ability to understand and participate in the plan of care.
      v. Encourage the family to have periods of uninterrupted sleep when appropriate
      vi. Promote patient/family centered care
         1) Discuss expectations and collaborate with patient/family
         2) Encourage patient/family to ask questions
      vii. Promote patient independence in Activities of Daily Living (ADL)
      viii. Promote comfort measures (if ordered or request order) by:
         1) Music therapy
         2) Therapeutic recreation
         3) Spiritual comfort
         4) Guided imagery
         5) Reminiscence therapy
         6) Encourage family/friends to visit
         7) Arrange for a child's visitation
         8) Arrange for pet therapy
         9) **Ar**range for physical or occupational therapy.
      ix. Patients shall be informed of their responsibilities upon admission and as necessary thereafter.
         1) These responsibilities include:
            a) Providing information
            b) Asking questions
            c) Following instructions
            d) Accepting consequences
            e) Following rules and regulations
            f) Showing respect and consideration
            g) Meeting financial commitments.
               i) See TCMC Patient Handbook.
      x. Encourage patient and/or their family to participate in their plan of care.
      xi. Assess for history of domestic violence/safety in home.
      xii. Request social services as appropriate.
         1) Initiate social services referrals for the following (including, but not limited to):
            a) Adoptions
            b) Infants going to foster care
            c) Patients with no prenatal care
            d) Teen moms
            e) Positive toxicology results
            f) Mothers of infants in Neonatal Intensive Care or in another facility
            g) All mothers and families experiencing Perinatal loss
            h) High risk mother or newborn, as defined by their provider.

K. STANDARDS OF CARE: INFUSION THERAPY

1. Central venous lines, including PICC lines, shall be assessed per PCS Central Venous Access Devices Procedure

B.**a. Note date of scheduled central dressing change, and change as indicated**

1. Peripheral IV **See" Standards of Care for Adults.** sites shall be assessed on admission, **each shift,**,ongoing and **upon** transfer from other nursing unit.
a. The following shall be assessed:
i. IV insertion date
ii. IV access type
iii. IV site and condition
iv. Patency
v. Dressing type and condition
vi. Date infusion change
vii. Date central venous dressing changed
2. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN.
3. Maintenance or continuous infusion shall be assessed every 2 **4** hours and PRN
4. Infusion Therapy: Nursing Interventions
a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
b. Document initials and date IV started directly on the dressing.
c. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
d. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor, phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site.
e. IV solutions and tubing shall be changed as follows:
i. Change every 4 days
1) All IV tubing
2) Add-on devices (neutral displacement connector MicroClave), antireflux, extension set, etc) and with tubing change
3) Rotate IV insertion sites
4) Commercially prepared solutions, if the bag is spiked once with initial start
5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback
f. Change every 24 hours.
i. All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours:
1) Lipids or lipid containing products
2) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc) and with tubing change
5. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
6. Label IV solutions with date and time IV solution hung.
7. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site.
8. Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
9. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
10. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
11. Swab Cap
a. **For**When a Central Venous line injection port is not in use, place an orange SwabCap on **all**
a. the unused port(s)

For a peripheral IV line a Apply a new Swab Cap: **to the unused port closest to the insertion site.**

Place a swab Cap on saline locks.

~~b. **Replace the Swab Caps:**~~
~~i. Every time the cap is removed~~
~~ii. Every 8 hours with routine IV flushing~~
~~2. PRN IV flushing~~

VII. REFERENCES

A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2012. *Guidelines for Perinatal Care* ***Seventh****~~ixth~~ Edition.* Washington, DC

B. American Academy of Pediatrics (2010*). Policy Statement – Hospital Stay for Healthy Term Newborns*. Retrieved on 01/12/2011: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;125/2/405.pdf

C. American Nurses Association (ANA). (2010). *Nursing scope and standards of practice*. Silver Spring, MD: Nursesbooks.org.

D. American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org

~~C.~~**E.** Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.

~~I. Bessemer, P. AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition (2007).Washington, D.C.~~

~~II. California Board of Registered Nursing. (2010). Nursing practice act business and professions code.Chapter 6 Nursing: Section 2725. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~

~~III. California Board of Registered Nursing. (2010). Standards of competent performance, California code of regulations, title 16, section 1443.5. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~

~~IV. California Board of Registered Nursing. (2010). California code of regulations, title 22, section 7012Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~

~~D.~~**F.** Mattson, S., & Smith, J.E. (Eds.) (2011) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia, PA: Saunders

ALLERGIES:_____

MEDICATIONS:

☐ Peripherally Inserted Central Catheter (PICC) Line Flush :

a) Maintenance- normal saline 10 mL Q 8 hours and PRN to flush port before and after use
b) Patients going home with PICC –One time order for heparin 20 units per lumen (supplied as heparin 10 units/mL vial) before discharge.

☐ Central Line Flush:

a) Maintenance- normal saline 10 mL Q 8 hours and PRN per PCS procedure *Central Venous Access Devices*

☐ Vita Port Flush

a) **CAUTION HIGH DOSE HEPARIN PORT; REMOVE AND DISCARD HEPARIN BEFORE MAINTENANCE FLUSH or ACCESSING**
b) Flush unused port every month with heparin 300 units (supplied as heparin 100 units/ mL, pre-filled syringe) for maintenance flushing.
c) Normal saline 10 mL PRN per PCS procedure *Central Venous Access Devices*
d) Heparinize port when de-accessing with heparin 300 units (supplied as heparin 100 units/ mL, pre-filled syringe)

☐ Medi-Port and Medi-Port Power Port Flush

a) **CAUTION HIGH DOSE HEPARIN PORTS; REMOVE AND DISCARD HEPARIN BEFORE MAINTENANCE FLUSH or ACCESSING**
b) Flush unused port every month with heparin 500 units (supplied as heparin 100 units/ mL, pre-filled syringe)
c) Normal saline 10 mL PRN per PCS procedure *Central Venous Access Devices*
d) Heparinize port when de-accessing with heparin 500 units (supplied as heparin 100 units/ mL, pre-filled syringe)

☐ Vas Cath or Perm-a-cath Flush

a) **CAUTION HIGH DOSE HEPARIN CATHETERS; REMOVE AND DISCARD HEPARIN BEFORE MAINTENANCE FLUSH or ACCESSING)**
b) Heparinize unused lumens once a week for maintenance flushing (if patient is not being dialyzed) and when de-accessing lumens.
c) Normal saline 10 mL PRN per PCS procedure *Central Venous Access Devices*
d) Heparinize lumens using heparin 1000 units/mL concentration (supplied in a 10 mL vial) with the exact volume in mLs located on the lumen (i.e. 1.6 is on lumen =1.6 mLs of the heparin 1000 units/mL concentration).

**** If heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.**

☐ Read Back all T.O./V.O.orders

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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8711-4010

CENTRAL VENOUS ACCESS DEVICE FLUSHES

DELETE: Approved for deletion at PPO committee 2/13/17. These orders are all in Cerner for electronic use. Approved for deletion at P&T 05.18.2017. Approved for deletion at MEC 06/17. Approved for deletion at PAC 07/17.

PRE-PROCEDURAL ORDERS

ALLERGIES: _____

CONSENT: Extracorporeal Shock Wave Lithotripsy with Possible Intravenous Py
_____side

CODE STATUS: ☑ Full

LAB/DIAGNOSTICS:

- ☐ Pregnancy test for female under 50 years unless previous hysterectomy UHCG
- ☐ Other: _____
- ☐ Other: _____

MEDICATIONS:

- ☐ _____
- ☐ _____
- ☐ _____

DIET:

- ☐ NPO 8 hours before procedure_____ except for small sips of water to take oral medication

IV:

- ☐ Start IV with D_5W with 20 gauge catheter and run 20 mL/hour
- ☐ Start IV with lactated ringers with 20 gauge catheter and run 20 mL/hour
- ☐ Buffered lidocaine intradermal for IV insertion.
  Note: For buffered lidocaine add 2 mL of sodium bicarbonate 8.4% to 2 mL vial of 1% lidocaine.

MEDICATIONS:

- ☐ Ancef 1 gram IVPB on call 30 minutes prior to procedure
- ☐ Ampicillin 1 gram IVPB on call 30 minutes prior to procedure
- ☐ Gentamycin _____ mg IVPB on call 30 minutes prior to procedure
- ☐ Levaquin 500 mg IVPB on call 30 minutes prior to procedure
- ☐ Other: _____
- ☐ Other: _____

8711-4010

Nurse's – Initials

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OUTPATIENT EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

POST-PROCEDURAL ORDERS

ASSESSMENT:

- ☐ Vital signs per PACU protocol.
- ☐ Evaluate treatment site and document site in progress note.
- ☐ Void prior to discharge

MEDICATIONS:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

DIET:

- ☐ May take liquids and diet as tolerated.

ACTIVITY:

- ☐ May ambulate as tolerated.

TREATMENT:

- ☐ Strain any voided urine – send any stone fragments to Lab for stone analysis.
- ☐ Send strainer home with instructions on use.
- ☐ Schedule for KUB 2 days before office follow-up visit
- ☐ Discharge home when discharge criteria met.
- ☐ Call for follow-up appointment in _____ days _____ weeks

8711-4010

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

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OUTPATIENT EXTRACORPOREAL SHOCK WAVE LITHOTRIPSY

Affix Patient Label

TRI-CITY HEALTHCARE DISTRICT
CLINICAL CONTRACT EVALUATIONS 2017

Vendor	Contract Number	Contract Type	Responsible Party	Responsible Dept	Expiration Date	Communication	Date Evaluated	Renew "R"/Not Renew "NR"	PHI Req'd	PHI Rec'd	MEC Review	PAC Review	BOD Rev
Tri-City Surgery Center	1007.3481C	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	3/30/2017	Yes	11/16/2016	R	Y	Y	6/26/2017	7/13/2017	
Tung, Howard MD	1007.3467C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
University of California, Irvine	1007.3118C	Laboratory Agreement	Tara Eagle	Laboratory	3/31/2017		11/29/2016	R	Y	Y	6/26/2017	7/13/2017	
University of California, San Diego Medical Center Clinical Laboratories	1007.878C	Laboratory Agreement	Tara Eagle	Laboratory	9/30/2017		11/29/2016	R	Y	Y	6/26/2017	7/13/2017	
University of California, San Diego Extension	1007.2475C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	11/19/2017	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
University of California, San Diego Skaggs School of Pharmacy and Pharmaceutical Sciences	1007.1437C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	4/27/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
University of San Diego	1007.1440C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	1/15/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
University of Southern California	1007.2499C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	1/7/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
University of St. Augustine for Health Sciences	1007.1447C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	12/2/2017	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
University of the Incarnate Word	1007.3312C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	8/22/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Urolithiasis Laboratory	1007.3120C	Laboratory Agreement	Tara Eagle	Laboratory	6/30/2017		11/29/2016	R	Y	Y	6/26/2017	7/13/2017	
Varshney, Neeta MD	1021.3394C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Viernes, Matthew E MD	1007.145C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	

TRI-CITY HEALTHCARE DISTRICT
CLINICAL CONTRACT EVALUATIONS 2017

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Village Square Nursing Center	1021.1796C	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	3/23/2017	Yes	11/16/2016	R	Y	Y	6/26/2017	7/13/2017	
Vista Community Clinic	1021.775C	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	8/30/2017	Yes	11/16/2016	R	Y	Y	6/26/2017	7/13/2017	
Vista Knoll Specialized Care	1021.782C	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	6/30/2017	Yes	11/16/2016	R	Y	Y	6/26/2017	7/13/2017	
Vista Unified School District	1007.1468C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	11/6/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Vista Unified School District: Adult Education/ROP	1007.1451C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	1/29/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Wadhwa, Ashish K MD	1007.146C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Walden University	1007.1452C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	3/28/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Wang, Anchi MD	1007.148C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Wang, Chunyang Tracy MD	1007.3167C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Warshawsky, Arthur B MD	1007.149C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Wei, Erman MD	1007.3080C	Physician-Recruitment Agreement	Jeremy Raimo	Business Development	7/31/2019	No	12/6/2016	NR	Y	Y	6/26/2017	7/13/2017	
West Coast University, Inc.	1007.2916C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	4/28/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Western Governors University	1007.1453C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	2/3/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Western Institutional Review Board	1007.998C	Clinical Study Agreement	Ingrid Stuiver	Clinical Research	8/30/2020	Yes	12/5/2016	R	Y	Y	6/26/2017	7/13/2017	

TRI-CITY HEALTHCARE DISTRICT
CLINICAL CONTRACT EVALUATIONS 2017

Vendor	Contract Number	Contract Type	Responsible Party	Responsible Dept	Expiration Date	Communication	Date Evaluated	Renew "R"/Not Renew "NR"	PHI Req'd	PHI Rec'd	MEC Review	PAC Review	BOD Rev
Western University of Health Sciences	1007.1453C	Clinical Affiliation Agreement	Elizabeth Fleming	Education	2/7/2018	Yes	11/18/2016	R	Y	Y	6/26/2017	7/13/2017	
Whitney, Janet DO	1007.3169C	Physician-Medical Director	Sharon Schultz	Wound Care	6/30/2018		11/5/2016	NR	Y	Y	6/26/2017	7/13/2017	
W.L. Gore & Associates	1007.2616C	Clinical Study Agreement	Ingrid Stuiver	Clinical Research	7/9/2017	Yes	12/5/2016	R	Y	Y	6/26/2017	7/13/2017	
Xoft, Inc.	1007.3418C	Clinical Study Agreement	Ingrid Stuiver	Clinical Research	3/31/2026	Yes	1/16/2017	R	Y	Y	6/26/2017	7/13/2017	
Yamanaka, Mark MD	1007.156C	Physician-Medical Director	Kapua Conley	Critical Care	6/30/2017		10/13/2016	R	Y	Y	6/26/2017	7/13/2017	
Yoo, Kevin MD	1007.157C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017	Yes	11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Yoo, Kevin MD	1027.3240C	Physician-Services Agreement	Jeremy Raimo	Neurosurgery	6/30/2017		12/6/2016	R	Y	Y	6/26/2017	7/13/2017	
Zaveri, Maulik MD	1007.3009C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2018		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
Zupancic, Michael MD	1007.2632C	Physician-Coverage Agreement	Sherry Miller	Emergency Room	6/30/2017		11/1/2016	R	Y	Y	6/26/2017	7/13/2017	
California Hospital Patient Safety Organization	1007.3136C	Participation Agreement	Marcia Cavanaugh	Risk Management	Evergreen	Yes	12/12/2016	R	Y	Y	6/26/2017	7/13/2017	
Cooperative of American Physicians, Inc.	1007.3423C	Services Agreement	Marcia Cavanaugh	Risk Management	Evergreen	Yes	12/12/2016	R	Y	Y	6/26/2017	7/13/2017	
RL Solutions	1021.469C	Software License and Service Agreement	Marcia Cavanaugh	Information Systems	Evergreen	Yes	12/12/2016	R	Y	Y	6/26/2017	7/13/2017	
Western Litigation, Inc.	1007.2394C	Professional Service Agreement	Marcia Cavanaugh	Legal and Compliance	6/30/2017	Yes	12/12/2016	R	Y	Y	6/26/2017	7/13/2017	
Accountable Healthcare Staffing, Inc.	1007.3466C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	

TRI-CITY HEALTHCARE DISTRICT
CLINICAL CONTRACT EVALUATIONS 2017

Vendor	Contract Number	Contract Type	Responsible Party	Responsible Dept	Expiration Date	Communication	Date Evaluated	Renew "R"/Not Renew "NR"	PHI Req'd	PHI Rec'd	MEC Review	PAC Review	BOD Rev
AMN Healthcare, Inc.	1007.2451C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Aureus Nursing, LLC	1007.2347C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Aureus Radiology, LLC	1007.2337C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Aya Healthcare, Inc.	1007.3396C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
CareStat LLC	1007.2237C	Services Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Cross Country TravCorps, Inc. dba Cross Country Staffing	1007.2452C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Decton Inc.	1007.2235C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Emerald Health Services	1007.3031C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Oceanside Healthcare Staffing Inc.	1007.2238C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Pacific Coast Healthcare LLC	1007.2236C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Solvis Medical Staffing	1007.2741C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	No	11/4/2016	NR	Y	Y	6/26/2017	7/13/2017	
SpringBoard, Inc.	1007.3453C	Professional Service Agreement	Kathy Topp	Bed Control Staffing	7/31/2017	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Trustaff Travel Nurses, LLC	1007.2455C	Staffing Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Valley Healthcare Systems	1007.3131C	Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	
Westways Staffing Services Inc.	1007.2239C	Service Agreement	Kathy Topp	Bed Control Staffing	6/30/2019	Yes	11/4/2016	R	Y	Y	6/26/2017	7/13/2017	

TRI-CITY HEALTHCARE DISTRICT
CLINICAL CONTRACT EVALUATIONS 2017

Vendor	Contract Number	Contract Type	Responsible Party	Responsible Dept	Expiration Date	Communication	Date Evaluated	Renew "R"/Not Renew "NR"	PHI Req'd	PHI Rec'd	MEC Review	PAC Review	BOD Rev
Blue Cross and Blue Shield Association	1007.2680C	Participation Agreement	Jeremy Raimo	Business Development	Evergreen	Yes		R	Y	Y	6/26/2017	7/13/2017	
Camp Pendelton Fire Department EMS	1007.2453C	Letter of Agreement (LOA)	Sharon Schultz	Nursing Admin	4/16/2022		11/22/2016	R	Y	Y	6/26/2017	7/13/2017	
Children's Hospital at Mission	1007.2933E	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	7/31/2016	Yes	1/18/2017	R	Y	Y	6/26/2017	7/13/2017	
Children's Hospital of Orange County	1007.2932E	Patient Transfer Agreement	Stephen Chavez Matzel	Case Management	7/31/2016	Yes	1/18/2017	R	Y	Y	6/26/2017	7/13/2017	
City of Carlsbad	1007.2427C	Letter of Agreement (LOA)	Sharon Schultz	Emergency Room	3/30/2018		11/14/2016	R	Y	Y	6/26/2017	7/13/2017	
Mental Health Systems, Inc.	1021.1887C	Memorandum of Understanding	Sharon Schultz	Nursing Admin	Evergreen		11/8/2016	R	Y	Y	6/26/2017	7/13/2017	
Outcome Sciences, LLC	1007.905C	Participation Agreement	Kapua Conley	Operational Improvement	12/31/2017		2/12/2017	R	Y	Y	6/26/2017	7/13/2017	
San Marcos Fire Department	1007.2428C	Letter of Agreement (LOA)	Sharon Schultz	Emergency Room	Evergreen		11/8/2016	R	Y	Y	6/26/2017	7/13/2017	
Women's Resource Center	1007.2611C	Memorandum of Understanding	Stephen Chavez Matzel	Case Management	8/31/2019	Yes	1/18/2017	R	Y	Y	6/26/2017	7/13/2017	

Governance & Legislative Committee
(No meeting held in
July, 2017)

Tri-City [illegible]ical Center
Audit, Compliance & Ethics Committee
July 20, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director Leigh Anne Grass; Jack Cumming, Community Member; Faith Devine, Community Member; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Cary Mells, M.D.; Physician Member
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, Acting CFO; Scott Livingstone, Interim CCO
Others Present:,	Jody Root, General Counsel; Teri Donnellan, Executive Assistant; Stacy Stelzriede, Partner, Moss Adams; Annie Norviel, Senior Manager, Moss Adams
Absent:	Director James Dagostino, DPT, PT; Kapua Conley, COO

	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 Grass and seconded by Mr. Cumming to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
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. Ratification of minutes – June 15, 2017	**It was moved by Mr. Schwatrz and seconded by Ms. Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified.**	
5. Old Business	None		
6. New Business A) Fiscal 2018 Financial	Mr. Ray Rivas introduced Ms. Stacy Stelzriede, Partner and Ms. Annie Norviel, Senior Manager. Mr. Rivas explained that Mr. John Blakey, who was the Partner at the beginning	**Information only.**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
Statement Audit Entrance – Moss Adams	of this audit as well as Mary Nguyen, Senior Manager have left the firm to pursue other interests. Mr. Rivas stated Ms. Stelzriede and Ms. Norviel have extensive experience in healthcare and will be stepping in for Mr. Blakey and Ms. Nguyen. Ms. Stelzriede provided a brief summary of her background and experience. She stated 70% of her work involves district, non-profit and for profit hospitals. Ms. Stelzriede introduced Ms. Annie Norviel, Audit Senior Manager who has worked with the finance team on our audits here at Tri-City for approximately seven years. Ms. Stelzriede stated Mr. Brian Conner continues as the Concurring Reviewer. His role is to perform a quality control review from a planning and field work perspective and is intended to be a fresh set of eyes. Mr. Dietlin commented that the committee initially heard of Ms. Stelzriede during initial discussions related to partner rotation. Ms. Stelzriede and Ms. Norviel presented information on the following: ➢ Required Communications to those Charged with Governance ➢ Our Responsibility Under US Generally Accepted Auditing Standards and Government Auditing Standards ➢ Audit Process • Internal Controls • Analytical Procedures • Substantive Procedures ➢ What is Materiality? ➢ Significant Audit Areas • Patient Revenue/Receivables • Cost Report Settlements • MOB Legal Proceedings • Self-Insurance Liabilities		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	• Line of Credit and Long-Term Debt (including new/refinanced debt in the current year and covenant compliance) ➢ Consideration of Fraud ➢ Deliverables ➢ Audit Timing Ms. Stelzriede explained the Auditor's role is to plan and perform the audit in accordance with generally accepted auditing standards and to design the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Ms. Stelzriede emphasized that the audit of the financial statements does not relieve the Board or management of their responsibilities. Ms. Stelzriede gave a detailed explanation of the definition of Materiality which is the amount of a misstatement that could influence the economic decisions of users, taken on the basis of the financial statements. She stated it is based on reasonable and appropriate calculating of quantitative and qualitative factors and used as a guide in scoping and testing. Ms. Norviel explained in detail the significant audit areas. She noted the MOB is a large item for this year and must be recorded properly. Ms. Norviel explained how the auditors will gather information to identify fraud-related risks of material misstatement and the procedures to be performed which will include but not be limited to testing and analyzing significant accounting estimates or biases. Ms. Fitzwilliam requested an explanation of IT controls. Ms. Stelzriede explained if there is a system conversion or issue with data they will bring in a specialist however under normal circumstances the auditors are trained to evaluate IT controls.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	With regard to timing of the audit, Ms. Stelzriede stated she expects to present the audit results to the committee and the Board at their September meetings. Committee members were given the opportunity to ask questions. Ms. Stelzriede also provided an Accounting Update. She noted there are not a whole lot of new standards for District Hospitals this year. Lastly, Ms. Stelzriede commented on the 2017 Health Care Conference which is scheduled on November 16-17, 2017 and which is often attended by C-Suite Executive Teams and Board members to share industry knowledge, best practices and new ideas. *Ms. Stelzriede and Ms. Norviel left the meeting at 9:05 a.m.*		
7. Oral Announcement of Items to be Discussed during Closed Session (Government Code Section 54957.7)	Chairperson Schallock made an oral announcement of the item listed on the agenda to be discussed during closed session which included approval of closed session minutes.		
8. Motion to go Into closed session	**It was moved by Mr. Cumming and seconded by Mr. Schwartz to go into closed session at 9:05 a.m. The motion passed unanimously.**		
9. Open Session	The committee returned to open session at 9:07 a.m. with attendance as previously noted.		
10. Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
11. Comments from Committee Members	There were no comments from members of the public.		
12. Date of Next Meeting	Chairperson Schallock stated the Committee's next meeting will be held on August 17, 2017.	**The committee's next meeting is scheduled for**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
		August 17, 2017.	
13. Adjournment	Chairperson Schallock adjourned the meeting at 9:08 a.m.		

AUDIT ENTRANCE

Tri-City Healthcare District

Presented by:

Stacy Stelzriede, Partner

Annie Norviel, Senior Manager

JULY 20, 2017

MOSS-ADAMS LLP

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Audit Committee

Tri-City Healthcare District

Dear Committee Members:

Thank you for your continued engagement of Moss Adams LLP, the provider of choice for healthcare organizations. We are pleased to present our audit plan for Tri-City Healthcare District for the year ended June 30, 2017. We would also like to discuss current-year developments and auditing standard changes that will affect our audit.

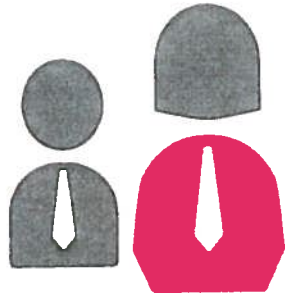
We welcome any questions or input you may have regarding our audit plan, and we look forward to working with you.

MOSS-ADAMS LLP

Your Dedicated Team

Stacy Stelzriede
Engagement Partner

Brian Conner
Concurring Reviewer



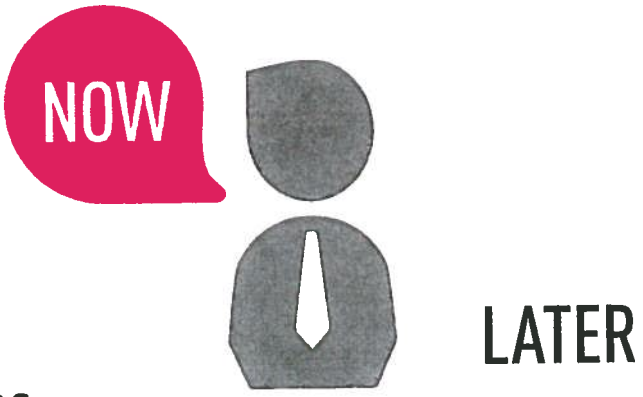
Annie Norviel
Audit Senior Manager

Other Recurring Team Members:

Kyle Rogers
Audit Senior

Required Communications to those Charged with Governance

- Auditor's responsibility under U.S. and government auditing standards
- Planned scope and timing of audit



- Significant audit findings
- Qualitative aspects of accounting practices
- Difficulties encountered in performing the audit
- Corrected and uncorrected misstatements
- Management representations
- Management consultations with other independent accountants
- Other audit findings or issues

Our Responsibility Under US Generally Accepted Auditing Standards and Government Auditing Standards

1 To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2 To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and Government Auditing Standards issued by the Comptroller General of the United States, and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3 To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4 To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, **we** are not required to design procedures for the purpose of identifying other matters to communicate to you.

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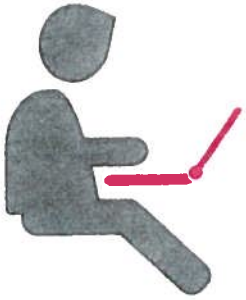
Audit Process

INTERNAL CONTROLS

- Includes Information Technology



ANALYTICAL PROCEDURES

- Revenues and expenses
- Trends, comparisons, and expectations

SUBSTANTIVE PROCEDURES

- Confirmation of account balances
- Vouching to supporting documentation
- Representations from attorneys and management
- Examining objective evidence

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What is Materiality?

It's the amount of a misstatement that could influence the economic decisions of users, taken on the basis of the financial statements

---

It's calculated using certain **quantitative** (e.g. total assets) and **qualitative** factors (e.g. covenants, expectations, or industry factors)

It's used to identify :

- Significant risk areas
- Nature, timing, extent, and scope of test work
- Findings or misstatements

Significant Audit Areas

Patient Revenue/Receivables

Cost Report Settlements

MOB Legal Proceedings

Self Insurance Liabilities

Line of Credit and Long-Term Debt (including new/refinanced debt in the current year and covenant compliance)

Consideration of Fraud

Auditors must consider fraud to
"improve the likelihood that auditors will detect material misstatements due to fraud in a financial statement audit."

How we gather information to identify fraud-related risks of material misstatement:

- Brainstorm with team
- Conduct personnel interviews
- Document understanding of internal control
- Consider unusual or unexpected relationships identified in planning and performing the audit

Procedures to be performed:

- Examine general journal entries for nonstandard transactions
- Evaluate policies and accounting for revenue recognition
- Test and analyze significant accounting estimates for biases
- Evaluate the business rationale for significant unusual transactions

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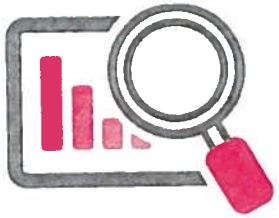
Deliverables



We will issue the following reports:

- Audit report on the consolidated financial statements as of and for the year ended June 30, 2017
- Report to Those Charged with Governance (Communicating required matters and other matters of interest)
- Report to Management (Communicating Internal Control Related Matters Identified in an Audit)

We have also been engaged to perform the following non-attest services:

- Assist in the drafting of the consolidated financial statements of Tri-City Healthcare District (excluding Managements' Discussion and Analysis)

Audit Timing

May 30, 2017

Planning meeting with management

→

May 30 – June 2, 2017

Interim audit procedures *(including test of implementation of internal controls)* for financial statements

→

July 20, 2017

Entrance Meeting with Audit Committee

↓

August 7 – August 25, 2017

Final fieldwork procedures for financial statements

→

September 2017 (TBD)

Discuss draft financial statements and auditor's reports with Management

→

September 2017 (TBD)

Audit Committee approval of statements and exit meeting

↓

On or before September 30, 2017

Finalize auditor's reports

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Accounting Update

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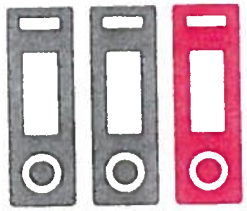
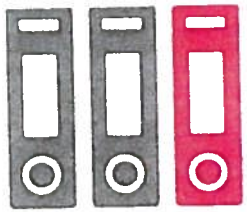
New Standards



GASB 76 The Hierarchy of GAAP for Governments

- Establishes two categories:
  - Category A: Formally approved statements by the GASB Board.
  - Category B: GASB Technical Bulletins and Implementation Guides.
- Effective for annual periods beginning after June 15, 2016.

Exposure Drafts



Leases

- Would treat all leases as financings (no classification of capital v. operating) similar to FASB ASU 2016-02.
- Includes non-cancellable period + periods covered by options to renew if reasonably certain to be exercised.
- Lessee would record an intangible asset (amortized over the shorter of its useful life or lease term) and present value of future lease payments as a liability.
- Lessor would record a lease receivable and deferred inflow of resources for cash received up front + future payments (revenue recognized over lease term in a systematic and rational basis).
- Final statement expected in late 2016 or early 2017.

About Moss Adams

MOSS-ADAMS LLP

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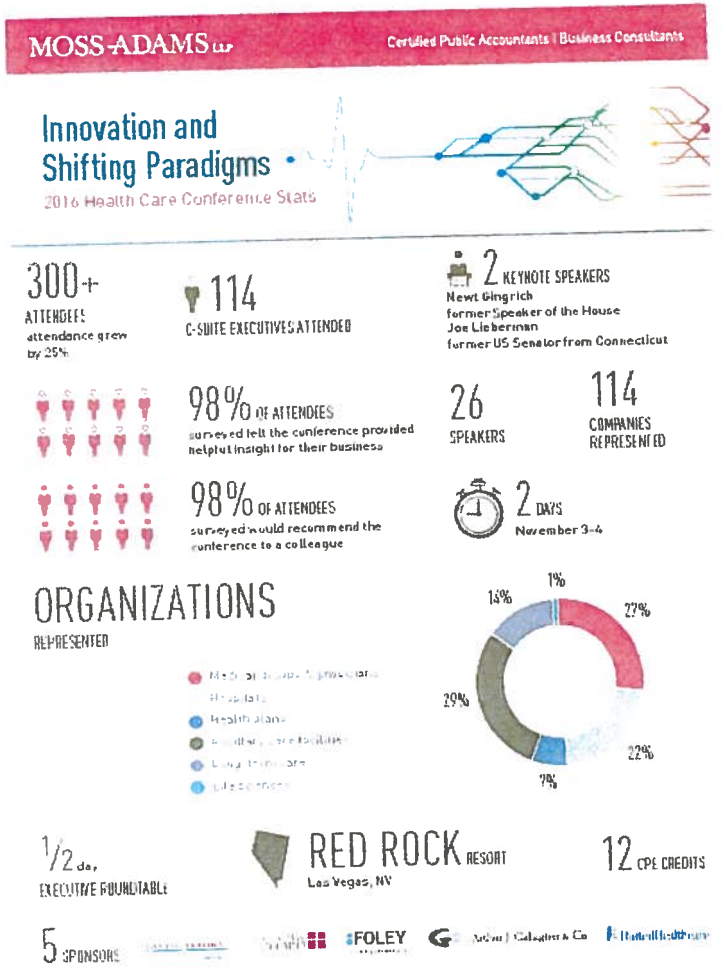
2017 Health Care Conference: Expect the Unexpected

SAVE THE DATE: Nov. 16 & 17, 2017

Moss Adams holds an annual two-day health care conference designed for our clients. The conference brings together notable C-suite and executive teams from across the country to share industry knowledge, best practices, and new ideas. This year, the conference will provide a forum for executives to discuss pressing topics including the Trump administration's progress and platform for repealing and replacing the ACA and the impact of further reforming health care.

2017 Keynotes Include:

- **Dr. Sanjay Gupta**, Emmy® award-winning chief medical correspondent for CNN and practicing neurosurgeon
- **Dr. Tom Coburn**, former Republican US senator from Oklahoma, physician, and two-time cancer survivor
- **Wendy Davis**, former Democratic state senator from Texas and a recognized leader on women's equality.
- **Ken Leonczyk**, legal and public policy expert and senior director of The Advisory Board Company
- **Dr. Lowell Catlett**, futurist, economist, and renowned speaker and author



Keeping You Informed

Keeping you informed about changes in the financial landscape is one of our top priorities. We closely monitor regulatory agencies, participate in industry and technical forums, and write about a wide range of general as well as industry-specific accounting, tax, and business issues. The goal? To provide you with actionable information and guidance to help your organization succeed.

Continuing education is vitally important to us, and we're happy to share our knowledge with you and your staff. We frequently offer a wide range of topical online seminars, many of which are archived and available on demand, allowing you to watch them on your schedule.

Our Services for Healthcare Organizations

ASSURANCE

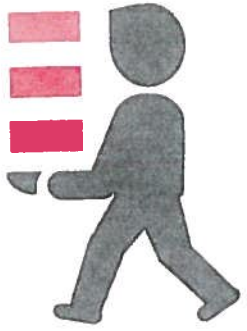
- Agreed-upon procedures
- Audits and reviews
- Single audits
- Compliance examinations pursuant to federal reporting requirements
- Employee benefit plan services
- Written acknowledgments and agreed-upon procedure engagements in connection with tax-exempt bond offerings

GENERAL CONSULTING

- Fraud investigation and forensic accounting
- IT consulting
- Strategic business planning
- Sustainability services
- Wealth services

HEALTHCARE CONSULTING

- ACOs and integrated delivery models
- 5010 readiness
- ICD-10 road map
- Chargemaster management
- Claims review and processing
- Coding and chart reviews
- Contract review
- Data analytics
- Dependent care audits
- Financial modeling and forecasting
- Hospital feasibility studies
- Litigation support
- Managed care operations
- Practice operation assessments
- Process improvement
- Regulatory compliance
- Reimbursement services
- Revenue cycle assessments
- Revenue recovery and enhancement
- Strategic planning



MOSS-ADAMS LLP

Moss Adams by the Numbers

HEALTH CARE CLIENTS
in the Western United States

Our team of dedicated professionals has served clients across the health care continuum for 38 years.

2,000
hospitals, health systems, independent practices, care centers, and more

200
professionals that focus on the health care sector*

101
years in business

265
partners

403
million dollars in revenue

4.9
staff-to-partner ratio

largest firm headquartered in the west

84%
staff retention rate

MOSS-ADAMS LLP

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Annie Norviel
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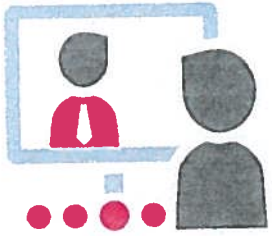
(858) 627-1484



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TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

June 29, 2017 – 1:30 o'clock p.m.
Assembly Room 1 – 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 June 29, 2017.

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:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Ray Rivas, Acting Chief Financial Officer
Norma Braun, Chief Human Resource Officer
Scott Livingstone, Interim Chief Compliance Officer
Gene Ma, M.D., Chief of Staff
Victor Souza, M.D., Incoming Chief of Staff
Greg Moser, General Legal Counsel
Adriana Ochoa, General Legal Counsel
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 Assembly Room 1 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 as presented. Director Schallock seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the June 29, 2017 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 June 29, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; two (2) matters of Potential Litigation; one Report Involving Trade Secrets, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; Conference with Legal Counsel regarding three (3) matters of Existing Litigation; and Approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Reno to go into closed session at 1:35 p.m. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:40 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:

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
Scott Livingstone, Interim Chief Compliance Officer
Greg Moser, General Legal Counsel
Adriana Ochoa, General Legal Counsel
Gene Ma, M.D., Chief of Staff
Victor Souza, M.D., Incoming 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 Schallock 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. Special Recognitions –

1) Dr. Gene Ma, Chief of Staff

Chairman Dagostino presented Dr. Gene Ma, Chief of Staff with a plaque for his outstanding service as Chief of Staff the past two years. Chairman Dagostino stated Dr. Ma has done an admirable job and has been instrumental in helping us move the hospital forward.

On behalf of nursing, Ms. Sharon Schultz presented Dr. Ma with a bouquet of flowers expressing their appreciation for his support in listening to the nurses, taking action when needed and being their partner.

Dr. Ma expressed his appreciation for the Board and Administration's support while representing the Medical Staff as Chief of Staff. He stated Nursing, as well as every member of the hospital staff has made this a very humbling experience and he is happy that he had the opportunity to work with so many great people, including all of our Board members.

13. Introductions

a) Anton Kushnaryov

Mr. Wayne Knight, Chief Strategy Officer introduced Dr. Anton Kushnaryov, who is Board Certified in Otolaryngology and his partner Dr. Julie Berry. Mr. Knight provided a brief summary of Dr. Kushnaryov's background and experience noting he completed his residency at UCSD and is relocating to the San Diego area from Santa Rosa, California. Mr. Knight stated Dr. Kushnaryov joined North Count ENT in March of this year.

Dr. Kushnaryov stated as part of his training at UCSD he received extensive experience and has a particular interest in head and neck cancer surgery, skin cancer reconstruction, endocrine including thyroid and parathyroid surgery and salivary gland surgery. In addition to receiving extensive experience in those areas, he gained some additional training in newer techniques such as in clinic vocal cord injection and Sinonasal endoscopy which is a minimally invasive procedure for some salivary gland diseases that hasn't been offered before in North County. Dr. Kushnaryov stated he is thrilled to be here and be part of the Tri-City family and serve patients in North County.

Dr. Julie Berry stated North County ENT was started by Dr. Lebovits who was unable to be here today. He commented that that both she and Dr. Lebovits have so many blessings to count with their practice and the addition of Dr. Kushnaryov is certainly one of them. She expressed her appreciation to Tri-City Board of Directors for helping make that happen.

On behalf of the Board of Directors, Chairman Dagostino welcomed Dr. Kushnaryov and thanked him for joining the Tri-City staff and serving our citizens in the North County.

b) Victor L. Souza, M.D., - Incoming Chief of Staff

Dr. Gene Ma introduced his successor, Dr. Victor Souza, Incoming Chief of Staff. Dr. Ma provided a summary of Dr. Souza's background and experience, noting he served the Vista Community Clinic for five (5) years until he founded Coastal Hospitalist Group which is the hospitalist group that cares for all of our inpatients. Dr. Ma stated Dr. Souza has also been a very active member of the Society of Medicine and has served as the Chair of the Bioethics Committee as well as the Medical Director of the Forensics Unit. Dr. Ma stated Dr. Souza is a phenomenal caring person, a consensus builder who is really vested in this organization. Dr. Ma stated he is excited to be turning the reigns over to Dr. Souza and knows we are in very good hands.

Dr. Souza stated he is grateful and honored for the opportunity to serve as the Chief of Staff. He is grateful to his predecessor, Dr. Ma for his work ethics and professionalism in making things happen. Dr. Souza commented that Dr. Ma was successful in establishing a great relationship with the Board and Administration and wants to follow in his steps in that regard. The Board, Administration and the Medical Staff have to be able to work together to be successful and he looks forward to that cohesiveness to achieve our goals and mission and re-advancing healthcare in North County and being the preferred center of care in our District.

Board members welcomed Dr. Souza.

14. Community Update –

1) American Heart Association Awards Recognition

Ms. Eva England, Cardiovascular Service Line Director stated Tri-City has received many awards from the American Heart Association and Ms. Jennifer Garrow, Regional Director of Quality & Systems Improvement with the American Heart Association/American Stroke Association is here today to present those awards.

Ms. Garrow presented the following awards to individuals representing each team as follows:

- Get With the Guidelines - Resuscitation Silver Award
- Get With the Guidelines – Heart Failure Gold Plus Target Heart Failure Honor Roll Achievement Award
- Get With the Guidelines – Gold Plus Target Stroke Honor Roll Award
- Mission Lifeline: STEMI Receiving Center Gold Recognition Award

Dr. El-Shereif gave an eloquent speech regarding the wonderful heart and cardiac care in North County. He stated he came to Tri-City almost three years ago and is very proud of what we do for the community. He expressed his appreciation to Dr. Spiegel, the Emergency Department and entire cardiac team and stated Tri-City is leading Cardiac Rehab in North County.

On behalf of the Board, Chairman Dagostino congratulated all the physicians and staff who were recognized today.

2) Ceremonial Presentation and Awarding of Community Healthcare Grant Awards – GiGi Gleason

Director Julie Nygaard introduced Ms. Gigi Gleason, Chairperson of the Community Healthcare & Alliance Grants Committee who presented today's grant awards.

Ms. Gleason stated she is extremely proud to present the grant award checks today to the 16 organizations that clearly rose to the top. Ms. Gleason presented awards to the following organizations:

- Alzheimer's San Diego
- Boys & Girls Clubs of Carlsbad
- Boys & Girls Clubs of Oceanside
- Boys & Girls Clubs of Vista
- Cal State San Marcos
- Casa de Ampara
- Coastal Roots Farm
- Emilio Nares Foundation
- Hospice of the North Coast
- Jacobs & Cushman San Diego Food Bank
- Miracle Babies
- North County Lifeline
- Solutions for Change
- The brother Benno Foundation
- The Elizabeth Hospice
- Women's Resource Center

Chairman Dagostino congratulated Ms. Gleason and the Grant Committee for their hard work and diligence in performing a fair assessment of the grant applications.

15. Report from TCHD Foundation, Glen Newhart, Chief Development Officer

Mr. Glen Newhart introduced four Foundation Board Members who are present today, Mr. Clay Gardner, Mr. George Brown, Mr. John Todd and Dr. David Tweedy.

Mr. Newhart reported 12,000 copies of the latest issue *For Good* were sent out to the community and early returns from that fundraising piece are encouraging. He noted individuals who haven't donated to the Foundation in several years are starting to give to Tri-City once again.

Mr. Clay Gardner gave a brief report on the upcoming Tri-City Hospital Foundation Golf Tournament that is scheduled for September 19th. He stated the event is almost sold out with only five spaces remaining. Mr. Gardner stated the Foundation is still accepting sponsorships to help with the event.

Mr. Newhart stated Dr. Ma will be coming back to the Foundation Board after a two-year sabbatical while fulfilling the role of Chief of the Medical Staff.

Mr. Newhart reported the Diamond Ball celebrity will be announced in approximately two weeks. As part of the Diamond Ball, Mr. Newhart reported there are two Legacy Award winners this year, Kevin & Ellen Stotmeister for the individual award and San Diego Imaging for the corporate award. Mr. Newhart stated both the Stotmeisters

and San Diego Image have provided a phenomenal amount of support, both in time and money and are true partners of the Foundation.

Mr. Newhart and the Foundation Board members presented two checks as follows:

1) $115,000 – will support construction of the room where the new SonoCine system will be housed;

2) $400,000 – represents an additional commitment to our Women's & Infant Services project through the NICU which will bring our total commitment between Labor & Delivery and NICU to well over $1.5 million in the past year.

Mr. Newhart expressed his appreciation to Administration, Labor & Delivery and the NICU in bringing these projects to fruition.

Chairman Dagostino stated the Foundation is extremely generous to our organization and we are extremely blessed for the support of their members.

No action was taken.

16. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO expressed his appreciation to Dr. Gene Ma for his exemplary service as the Tri-City Chief of Staff for the past two years. He stated Dr. Ma truly facilitated improvement and the collaboration between the Medical Staff, Administration and the Board of Directors which is so important in moving the organization forward.

Mr. Dietlin stated Dr. Victor Souza's energy is magnetic. He stated Dr. Souza is highly respected by the Medical Staff, Administration and everyone in this organization. Mr. Dietlin stated he is excited to be working with Dr. Souza in an expanded relationship as we move forward.

Mr. Dietlin reported he had the opportunity to attend the Auxilians Awards Recognition Luncheon this past weekend. He stated the Auxilians are a tremendous asset to this hospital and is often the first and the last experience a lot of the patients have while at the hospital. Mr. Dietlin stated the Auxilians are truly an example of what it means to be a community hospital. Their time and commitment are exemplary.

Mr. Dietlin expressed his appreciation to Mr. Pat Morocco for this service and welcomed Ms. Mary Gleisberg as she moves into the role leading the hundreds of Auxilians moving forward next year.

Mr. Dietlin reported with the Board's support we completed an agreement to expand and ensure quality orthopedics on a go forward basis in this community.

Mr. Dietlin reported Mental Health is another area that is underserved in every community and virtually every state and across this nation. He stated implementation of the Crisis Stabilization Unit has resulted in improved Emergency Department wait times and we will continue to focus on Mental Health and the Emergency Department throughput.

No action was taken.

17. Report from Acting Chief Financial Officer

Mr. Rivas reported on the Fiscal Year to Date Financials as follows (Dollars in Thousands):

- Operating Revenue – $310,186
- Operating Expense – $312,708
- EBITDA- $14,305
- EBITDA Excl. HUD Financing Chg - $17,709
- EROE - $371
- EROE Excl. HUD Financing Chg - $3,775

Other Key Indicators for the current year driving those results included the following:

- Average Daily Census – 180
- Adjusted Patient Days – 102,569
- Surgery Cases – 5,770
- Deliveries – 2,339
- ED Visits – 57,502

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $29,880
- Operating Expense – $30,348
- EBITDA - $1,558
- EROE – 296
-

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 175
- Adjusted Patient Days – 9,244
- Surgery Cases – 501
- Deliveries – 188
- ED Visits – 5,205

Mr. Rivas reported on the following indicators for FY17 Average:

- Net Patient Accounts Receivable - $43.3
- Days in Net Accounts Receivable – 49.6

No action was taken.

18. New Business

a. Consideration to approve Resolution No. 786, A Resolution of the Board of Directors of Tri-City Healthcare District Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2017 and ending June 30, 2018, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve Resolution No, 786, A Resolution of the Tri-City Healthcare District Board of Directors Establishing the Appropriations Limit for TCHD for the Fiscal Year Commencing July 1, 2017 and ending June 30, 2018, in Accordance with Article XIIB of the Constitution of the State of California, Code of the State of California. Director Kellett seconded the motion.

Mr. Moser explained this is a resolution that is a statutory requirement that sets an appropriation limit for the District. He further explained it is a calculation that sets the maximum amount the District could collect in tax revenue and is based on cost of living and population statistics. Director Schallock explained in other words, Special Districts have an apportionment of the 1% property tax that is collected and the resolution reflects the maximum Tri-City could receive.

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. Consideration to approve a Physician Recruitment Agreement with Dr. Ashish Kabra, General Cardiology

Mr. Wayne Knight, Chief Strategy Officer presented an agreement to support the recruitment of Dr. Ashish Kabra who is joining Blue Coast Cardiology with Dr. Spiegel. He explained the terms of the recruitment agreement which were outlined in the agenda materials.

Mr. Knight stated as the Board went through the Strategic Planning process in May and June, Administration was directed to get active in recruitment of additional cardiologists to support our Cardiology program and this is the first recruit.

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. Ashish Kabra, not to exceed $755,000 in order to facilitate this General Cardiology physician practicing medicine in the communities served by the District. Director Mitchell seconded the motion.

Chairman Dagostino stated this recruitment is designed to help bring in and replace our retiring physician population.

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. Consideration to partnership with the County on the *Live Well San Diego* Program

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve a partnership with the County of San Diego on the *Live Well San Diego* Program. Director Schallock seconded the motion.

Director Nygaard stated this program was presented at last week's Community Healthcare & Alliance Committee meeting and is designed to build a healthier community. She stated there are numerous organizations in San Diego participating in this program and it is the recommendation of the committee that Tri-City join. Director Nygaard stated there is no fee to join and simply requires us to cooperate and try to build a healthier community.

Chairman Dagostino stated he personally believes this is an excellent program for Tri-City to join. He noted our sister hospital to the east, Palomar is also a member.

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**

19. Old Business

a) Consideration of Action to Direct Staff to Prepare Resolution of Application for Proposed Annexation of LAFCO-Recommended Unserved Areas (South Carlsbad and Vista).

General Counsel, Ms. Andrea Ochoa summarized a memorandum that was distributed at the Dais and made available to the public that included information on the Benefit of Proposed Annexations, the LAFCO Annexation Process, Staff Progress, CVRA Considerations and a recommendation.

Ms. Ochoa stated at last month's Board meeting the Board approved Resolution 785 which was a dual resolution to transition from at large elections to district based elections. It also considered these LAFCO proposals in terms of the annexations and directed the CEO to move forward with hiring consultants necessary to execute both the annexations and the transition from at large elections to district based elections. She explained that since adoption of that resolution the first draft of materials have been submitted to LAFCO including the plat maps and legal descriptions. She stated the next step is to draft a Resolution of Application for annexation of these two areas into our jurisdictional boundaries. With the Board's approval, the Resolution will be brought back to next month's meeting for approval to begin the process of formally annexing these areas into the District's boundaries.

Ms. Ochoa stated that the second issue is the California Voting Rights Act issue. She explained that the District received a demand letter from Shenkman and Hughes demanding that we transition from an at large to a district based election system. In response, we adopted a Resolution stating we would comply and that Resolution sets forth a timeline of proposed actions. Ms. Ochoa stated we recognize that a number of members of the public are

concerned about a prospective delay stemming from legal LAFCO annexation and we solicited and received proposals from demographers that can assist the District with the transition from at large to district based elections. She noted one of the demographers stands out in particular for their work with healthcare districts as well as their work with the City of Vista, Oceanside and Carlsbad. Ms. Ochoa stated the District plans to proceed with parallel tracking for the drawing of district maps. For example, we will ask our demographers, once they are retained, to prepare district maps for the current district's jurisdictional boundaries and for the proposed jurisdictional boundaries once the annexation moves forward. She noted the timeline is going to be dictated by LAFCO and how quickly they can process the annexations.

Ms. Ochoa stated we have received information from the Registrar of Voters that a Resolution explaining the transition from at large to district based elections and maps are due to the Registrar of Voters by April 26, 2018 in order to be implemented for the November 2018 election. She emphasized that the District is going to try and meet that timeframe however if that is not possible the purpose of the parallel tracking is so that we can have sub-districts drawn to meet that deadline whether it is with the current jurisdictional boundaries or hopefully with the proposed jurisdictional boundaries.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors authorize the CEO and General Counsel to prepare for the Board's review at the next regular Board meeting, a Resolution of Application for the proposed annexations of the two currently unserved areas recommended by LAFCO, located in Shadowridge and south Carlsbad, into the Tri-City Healthcare District. Director Kellett seconded the motion.

Chairman Dagostino reiterated that the District is attempting to be as efficient as possible by drawing two maps recognizing that we have the annexation to consider.

With regard to public hearings, Ms. Ochoa stated there will be two hearings before maps are drawn, two meetings after the proposed maps are drawn and one after that to adopt the Resolution under the Health and Safety Code. She noted the District has the discretion to hold the meetings town-hall style or at other locations however we anticipate meetings will take place here at the hospital.

Director Schallock requested confirmation that the bottom line is that we will have district based elections at the November 2018 election. Ms. Ochoa responded that is correct, ideally that will be with Shadowridge and south Carlsbad in the jurisdictional boundaries, however if LAFCO cannot process those annexations in time the intention will be to have district based elections with the current jurisdictional boundaries.

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) Update Regarding Resolution No. 785, A Resolution of the Board of Directors of the Tri-City Healthcare District Outlining Intention to Transition from At-Large to District Based Elections Pursuant to Elections Code 10010(e)(3)(A)

Discussion of this agenda item was discussed in conjunction with agenda item 19 a).

c) Update on Board Workshop

Chairman Dagostino reported the Board Workshop is scheduled for September 7, 2017 and will be held onsite. Chairman Dagostino stated he spoke to all of the individuals that Board members recommended as potential Board Facilitators, including Mr. Larry Walker, the Camden Group and Jim Rice. He stated Mr. Walker no longer provides this service and the Camden Group was more interested in how to help us develop business strategies. Therefore he has engaged our former facilitator Jim Rice who has agreed to take a look back at our previous self-assessments and compare to our upcoming self-assessment and provide insight on how the Board has grown and recommend areas where a change may be beneficial. Chairman Dagostino stated he has also recommended that Mr. Rice provide some practical solutions for a more effective Board.

20. Chief of Staff

a. Consideration of June 2017 Credentialing Actions involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on June 26, 2017.

It was moved by Director Nygaard to approve the June 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on June 26, 2017. 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:**	**None**

21. Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Nygaard seconded the motion.

It was moved by Director Reno to pull items a 21 D. 11) Approval of an agreement with Kone, Inc. for Elevator Maintenance and Service for a term of 60 months, for a cost not to exceed $270,320; 21 D. 14) Approval of a renewal of an agreement with Registry and Traveler Vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and Allied Health for the remaining term of two years, beginning July 1, 2017 through June 30, 2019, for a new cost for the term of $18.5M; 21 D.

19) Approval of an extension to an Employee Leasing Agreement with Dr. Tannaz Ebrahimi Adib, for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA; 21 D. 21) Approval of a management agreement with Comprehensive Pharmacy Services to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) plus four (4) years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending four (4) years from implementation, for a total cost for the term of $1,107,242; 21 D. 22) Approval of a renewal of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory Services for a term of 12 months, beginning July 1, 2017, and ending June 30, 2018, at an annual cost of $695,000 and a total cost of the term of $695,000; 21 E. 2) d) Purpose and Responsibility of Risk Management and 21 E. 3) d) Education Documentation of Activities Policy. Director Kellett seconded the motion. Director Reno also noted she would be voting "no" on the minutes.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

22. Discussion of items pulled from Consent Agenda

Director Reno who pulled item 21 D. 11) Approval of an agreement with Kone, Inc. for Elevator Maintenance and Service for a term of 60 months, for a cost not to exceed $270,320 expressed concern that elevators have been inoperable many times in the last year. Mr. Conley explained we have monies allocated in the capital budget this year for upgrading our existing elevators. He further explained that this agenda item is simply a renewal of our annual maintenance cost for those elevators which is actually a reduction.

It was moved by Director Schallock to approve an agreement with Kone, Inc. for Elevator Maintenance and Service for a term of 60 months, for a cost not to exceed $270,320. Director Mitchell 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**

Director Reno who pulled item 21 D. 14) Approval of a renewal of an agreement with Registry and Traveler Vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and Allied Health for the remaining term of two years, beginning July 1, 2017 through June 30, 2019, for a new cost for the term of $18.5M stated $18.5 million seems like an exorbitant price for Registry and Travelers. Ms. Schultz clarified the contract is for three (3) years and began in July of 2016. She explained the reason the contract was brought back to the Board is because the initial contract amount was insufficient to cover the costs. Ms. Schultz stated we typically spend approximately $6 million/year on Registry and Travelers. Ms. Schultz stated that we currently have 58 nurses out on some type of leave of absence and we cannot fill those positions as they are protected. Ms. Braun stated Family Medical Leave is 12 weeks, intermittent leave is 12 weeks however it can be taken sporadically and baby bonding with pregnancy leave is a maximum of seven months. Ms. Braun stated from an employee perspective this is a great benefit, but from a staff perspective it does create some issues. Ms. Braun stated we need to continue to meet our ratios, thus the need for Registry.

It was moved by Director Kellett to approve a renewal of an agreement with Registry and Traveler Vendors, with flexibility to add or delete agencies, for supplemental staffing for nursing and Allied Health for the remaining term of two years, beginning July 1, 2017 through June 30, 2019, for a new cost for the term of $18.5M stated $18.5 million . 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**

Director Reno who pulled item 21 D. 19) Approval of an extension to an Employee Leasing Agreement with Dr. Tannaz Ebrahimi Adib, for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA questioned who interviews these physicians and how are they selected. Mr. Knight responded that there is a mechanism for recruiting physicians, however this agenda item does not pertain to physician recruitment. He stated it is an extension of an employee leasing agreement which provided that current Venus employees can remain on Venus's payroll and the district will reimburse while we vet and hire those individuals that we feel are most qualified.

It was moved Director Kellett to approve an extension to an Employee Leasing Agreement with Dr. Tannaz Ebrahimi Adib, for non-medical staffing at 2067 W. Vista Way, Suite 160, Vista, CA moved. Director Mitchell 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**

Director Reno who pulled item 21 D. 21) Approval of a management agreement with Comprehensive Pharmacy Services to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) plus four (4) years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending four (4) years from implementation, for a total cost for the term of $1,107,242 questioned if we are combining the inpatient/outpatient pharmacy into one. Mr. Conley stated this is our retail pharmacy initiative and we will be expanding from an inpatient to an outpatient operation. He explained that running a retail pharmacy requires a certain skillset and we are working with CPS to help us maintain compliance and licensure. Ms. Tory Hong, Director of Pharmacy stated that retail pharmacy falls under a separate licensure and is run totally differently from the inpatient pharmacy which is why we are reaching out to CPS to help us start up the program. She explained that because we are 340b hospital and we want to leverage that we need to make sure we stay compliant with all of its complicated regulations. Mr. Moser cautioned that the item related to the construction of the retail pharmacy was not pulled and is not up for discussion.

It was moved by Director Schallock to approve a management agreement with Comprehensive Pharmacy Services to operate and manage the Outpatient Retail Pharmacy service for the duration of the implementation plan (pre-opening) plus four (4) years, and to renew the inpatient management agreement to be co-terminus with the OP agreement, ending four (4) years from implementation, for a total cost for the term of $1,107,242. Director Kellett seconded.

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**

Director Reno pulled item 21 D. 22) Approval of a renewal of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory Services for a term of 12 months, beginning July 1, 2017, and ending June 30, 2018, at an annual cost of $695,000 and a total cost of the term of $695,000 expressed concern with the annual cost. Mr. Conley explained that North Coast Pathology has not had any adjustment to their current fee schedule for seven years and it was necessary to bring the contract up to 75% of fair market value.

It was moved by Director Reno to approve a renewal of an agreement with North Coast Pathology Medical Group for Clinical & Anatomic Pathology Laboratory Services for a term of 12 months, beginning July 1, 2017, and ending June 30, 2018, at an annual cost of $695,000 and a total cost of the term of $695,000. 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:**	**None**

Director Reno who pulled item 21 E. 2) d) Purpose and Responsibility of Risk Management questioned whether Risk Management falls under PAC purview. Ms. Schultz stated that any matters related to Risk Management are reported out at PAC.

It was moved by Director Kellett to approve Purpose and Responsibility of Risk Management Policy. Director Mitchell 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**

Director Reno who pulled item 21 E. 3) d) Education Documentation of Activities Policy questioned what type of education this policy refers to. Director Mitchell stated the policy refers to education for staff that is provided or facilitated by the Education Department. Ms. Schultz stated we are required to keep track of what we teach to meet various regulatory requirements.

It was moved by Director Mitchell to approve Education Documentation of Activities Policy. 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:**	**None**

Director Reno reaffirmed that she is voting no on the minutes.

23. Reports (Discussion by exception only)

24. Legislative Update

Chairman Dagostino reported he attended his first CHA Governance Forum meeting in Sacramento earlier week where he was appointed to sit as a Trustee for the California Hospital Association to discuss the California Hospital Association's posture on California legislation. He stated he appreciates the opportunity to serve on this forum and believes Tri-City is in sync with CHA's positions on pieces of legislation.

25. Comments by members of the Public

Chairman Dagostino recognized former Patient Representative Doreen Johnson. Ms. Johnson stated that her position was eliminated after 12 years. She commented on the history of the patient rep position and the benefits of this service. She urged the board to reconsider this decision.

26. Additional Comments by Chief Executive Officer

Mr. Dietlin did not have any additional comments.

27. Board Communications

Director Schallock personally thanked Dr. Ma for his service as Chief of Staff. He stated as a former Board Chair he had the opportunity to work closely with Dr. Ma for a period of time and he believes the hospital is in a much better position in working towards the goals to provide quality care for our patients.

Director Schallock stated he had the opportunity to open the Pharmacy at the Vista Community Clinic when it moved to Vale Terrace where Dr. Souza was on staff. He stated he looks forward to working with Dr. Souza as we go forward.

Director Schallock commented on the American Hospital Awards that were presented today and were quite impressive. He stated he appreciated having the opportunity to hear about those awards today.

Lastly, Director Schallock commented on the district boundaries. He emphasized that no matter what happens, there will be boundaries in place for the 2018 election where at least three districts will be up for election as terms expire.

Director Reno expressed her appreciation to Dr. Ma who has helped the Board during his tenure make proper decisions. She stated Tri-City Hospital has benefited by his leadership and he will be missed. Director Reno also welcomed Dr. Souza.

Director Reno stated as a Board member she was very sorry to see the Patient Rep position eliminated and hopes we are able to resurrect that position in some fashion.

Lastly, Director Reno reported she attended the Auxilians Annual Awards & Installation. She calculated that the Auxilians volunteered 1,227,000 hours of service this past year which is exemplary.

Director Nygaard expressed her appreciation to Dr. Ma for his outstanding service. She stated he made it easier for the Board to understand the Medical Staff and he strengthened the relationship between the Board and the Medical Staff.

Director Nygaard commented that Dr. Souza has big shoes to fill and she is confident he is up to the task.

Lastly, Director Nygaard commented on the American Heart Association awards. She stated that Tri-City is truly the hospital to come to for cardiac care issues.

Director Grass stated she appreciated opportunity to work with Dr. Ma for this brief period of time and thanked him for his service.

Director Grass welcomed Dr. Souza.

Director Grass congratulated the Stroke Team, the Cardiac Cath Lab, the Resuscitation Team and the Heart Failure Team for their awards today.

Director Grass commented that she was unaware that there had been layoffs and she appreciated Ms. Johnson bringing that information to the Board. In the meantime, she expressed her appreciation to Ms. Johnson for her years of service and everything she has done for patients and families while an employee here.

Director Mitchell expressed her appreciation to Dr. Ma for his years of service and ability to navigate in some turbulent times. She stated that Dr. Ma's was a strong advocate for the Medical Staff and brought the Medical Staff Office into the 21st century.

Director Mitchell welcomed Dr. Souza.

Director Kellett thanked Dr. Ma for his service and welcomed Dr. Souza. He stated the Chief of Staff of the hospital is an essential figure and although they work for the Medical Staff the hospital cannot get by without them.

28. Report from Chairperson

Chairman Dagostino echoed his colleague's comments related to Dr. Ma and Dr. Souza. He stated Dr. Ma has set a very high bar for Dr. Souza and has elevated our Medical Staff.

Chairman Dagostino also commented on the American Heart Association awards. He stated we are very fortunate to be living in this community.

29. Chairman Dagostino reported the Board would be returning to Closed Session to complete unfinished business at 5:48 p.m.

31. The Board returned to open session with all Board members present.

32. Chairman Dagostino reported no action was taken in closed session.

33. Hearing no further business, Chairman Dagostino adjourned the meeting at 6:55 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

June 22, 2017 – 3:00 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 3:00 p.m. on June 22, 2017.

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:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Scott Livingstone, Interim Chief Compliance Officer
Norma Braun, Chief Human Resource Officer
Wayne Knight, Chief Strategy Officer
Jeremy Raimo, Senior Director, Business Development
David Bennett, Chief Marketing Officer
Glen Newhart, Chief Development Officer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 3:07 p.m. in Assembly Room 3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Mitchell to approve the agenda as presented. Director Nygaard 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. Moser, made an oral announcement of items listed on the June 22, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators and one Report on Trade Secrets with a disclosure date of June 22, 2017.

Mr. Bennett and Mr. Newhart left the meeting at 3:10 pm.

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.

Chairman Dagostino adjourned the meeting to Closed Session at 3:10 p.m.

7. The Board returned to Open Session at 4:03 p.m. with all Board Members present with the exception of Directors Grass.

Mr. David Bennett and Mr. Glen Newhart rejoined the meeting at 4:03 p.m.

8. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

9. Open Session

1) Consideration of proposal for establishment of Section 1206b Clinic.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors approve the execution and delivery of all agreements and documents necessary or advisable to consummate the transaction of forming a 1206(b) Orthopedic clinic with Orthopedic Specialists of North County. Director Schallock seconded the motion.

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**

2) Board of Directors Public Workshop for the purposes of review, discussion and possible action on the Operating and Capital Budgets for Fiscal Year 2018.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors approve the operating and capital budgets for FY2018 as presented. Director Nygaard seconded the motion.

Mr. Ray Rivas, Chief Financial Officer provided a summary of changes that were made to the proposed budget, including eliminating the allocation for Community Healthcare Grants for the new fiscal year, a reduction in deliveries and projections by 1% as well as a reduction in volume for Emergency Department visits.

Director Reno requested clarification on legal fees, salaries and expenses. Mr. Rivas explained legal fees have been reduced due to significant reimbursement from insurance companies related to the MAC litigation and the most significant change to salaries is due to the Orthopedic Specialists of North County transaction.

Director Reno questioned where the Medical Office Building and Consultant fees are recorded in the budget. Mr. Rivas stated the Medical Office Building has not yet been recorded however he anticipated recording it as an asset in June. Consultant fees are reflected in Other Purchased Services.

With regard to cash on hand, Mr. Rivas stated we have 92 days cash on hand in May and $78 million in liquidity.

Chairman Dagostino commented that it is an aggressive budget that overlays the strategic initiatives.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Kellett, Mitchell, Nygaard, and Schallock**
NOES:	**Directors:**	**Reno**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Grass**

3) Approval of attendance by Board Chair to attend quarterly CHA Governance Forums in Sacramento, CA

Chairman Dagostino explained he has been appointed as a Trustee to the CHA Governance Forum. He stated meetings are held quarterly, four (4) meetings per year where Trustees discuss the California Hospital Association's posture on California legislation. He noted expenses for attendance are minimal are limited, such as transportation.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve attendance by the Board Chair at quarterly CHA Governance Forums in Sacramento, CA. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Dagostino**
ABSENT:	**Directors:**	**Grass**

11. There being no further business, Chairman Dagostino adjourned the meeting at 4:19 p.m.

_____

James J. Dagostino
Chairman

ATTEST:

Laura E. Mitchell
Secretary

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

June 30, 2017

Steven Dietlin
Chief Executive Officer
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Re: ACHD Membership Renewal Invoice

Dear Steven,

Thank you for being a loyal Member of the Association of California Healthcare Districts (ACHD). Enclosed you will find your Membership renewal invoice and a brochure detailing the benefits of Membership in ACHD. The Association is happy to report that another year has gone by without a dues increase!

ACHD represents the diverse needs of Healthcare Districts throughout the state by: enhancing public awareness; training and educating our Members; and representing our Members in front of the Legislature, Governor, and State Agencies. We firmly believe that "Members Drive Change" and that taken together, we have the unity and strength which will enable Healthcare Districts to continue to deliver the best possible health services to their communities.

In the past year, your Association:

- Successfully sponsored state legislation to provide Healthcare Districts that own or operate a hospital or clinic with design build authority;
- Collaborated with Legislators to support successful legislation to allow Critical Access Hospitals (including 20 Healthcare Districts) to directly employ physicians;
- Started a collaboration with the Stanford Health Improvement Program to bring health education and initiatives to Districts;
- Represented Healthcare District's interests and provided testimony at an informational hearing of the Assembly Local Government Committee and a hearing and advisory meeting of the Little Hoover Commission relating to Healthcare Districts;
- Completed the merger of ALPHA Fund Workers Compensation with BETArma; which by Agreement, generates nearly $10 million in support of the Association through 2024;
- Revised the ACHD dues structure to maintain or reduce annual dues for our Members and further enhance the value of our programs;
- Experienced significant Member participation and attendance at educational programs.

In the coming year, the Association will:

- Create policy and regulatory priorities and work directly with Legislators and State Agencies through our Advocacy Team, Advocacy Committee and Workgroups;

- Enhance our District specific training and certification programs during our Leadership Academy, Legislative Day and Annual Meeting;
- Host the Association's first ever educational event related solely to Wellness and Prevention;
- Introduce new opportunities for Districts to collaborate through webinar trainings and regional roundtables.

Thank you for your Membership in the Association of California Healthcare Districts. Your continued involvement is important and very much appreciated. And as a reminder, please submit your payment no later than July 30, 2017 to avoid a lapse in your Membership.

Sincerely,

Julie Nygaard
Board Chair, ACHD

Kenneth B. Cohen
Executive Director, ACHD

Cc: James Dagostino, Board Chair

ACHD
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Invoice

Invoice No.	**17004718**
Date	07/01/2017
Terms	30 Days

Tri-City Healthcare District
Attn: Accounts Payable
4002 Vista Way
Oceanside, CA 92056

Qty.	Description	Rate	Amount
1	Adjusted Membership Dues 7/1/17 through 6/30/18	25,000.00	25,000.00
		Total	**$25,000.00**

Association of California Healthcare Districts
by check:
P.O. BOX 619084
Roseville, CA 95661

By wire:
Wells Fargo Bank
Account #: 4121-229975
ABA/Routing #: 121000248

Stakeholder Experience

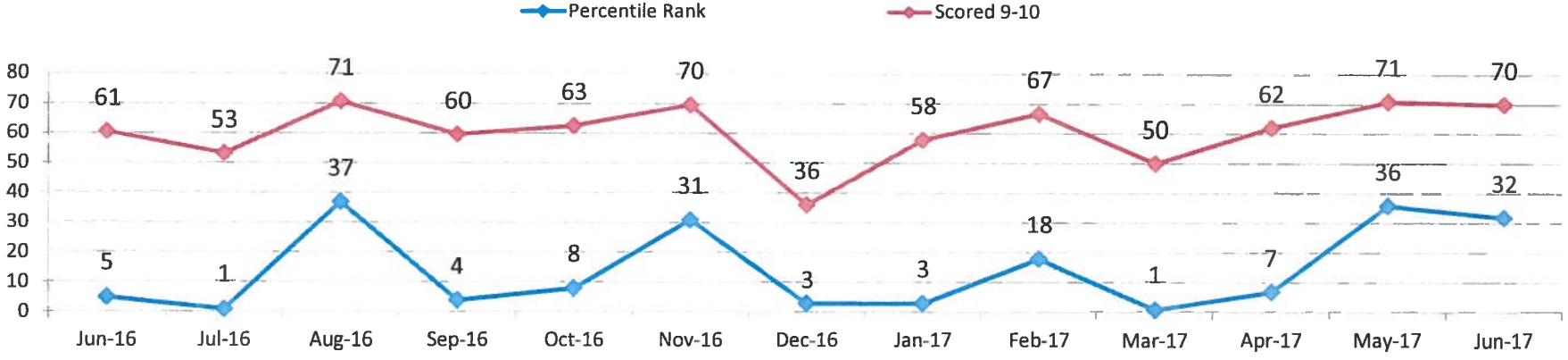
Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

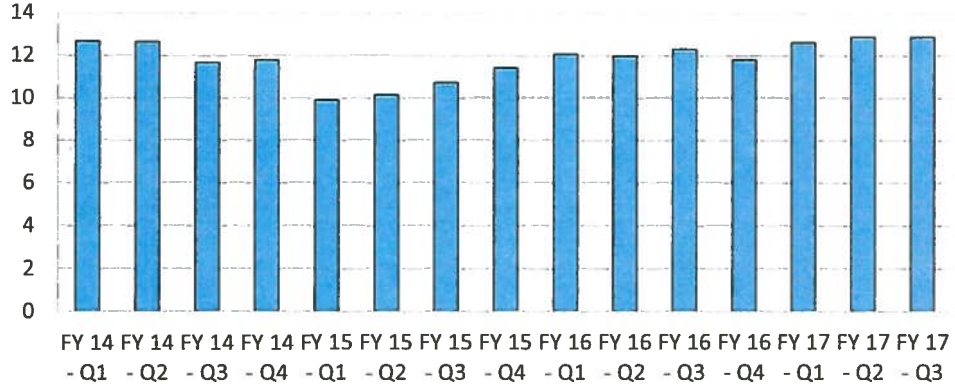
HCAHPS (Top Box Score)

Hospital Consumer Assessment of Healthcare Providers & Systems

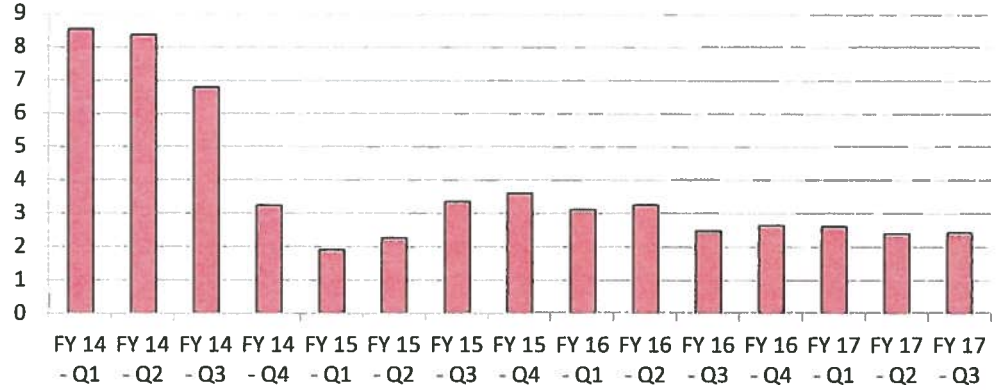
Overall Rating of Hospital (0-10)



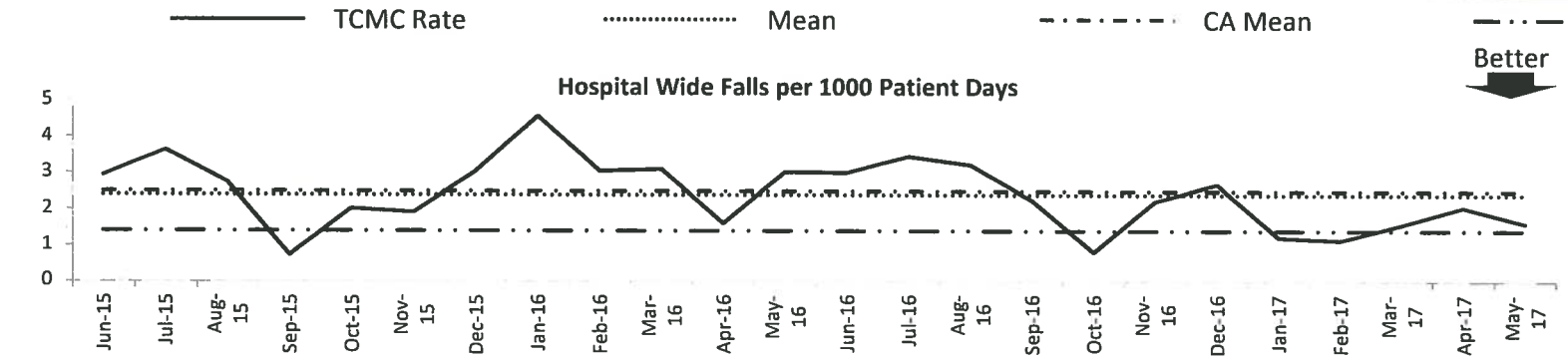
Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



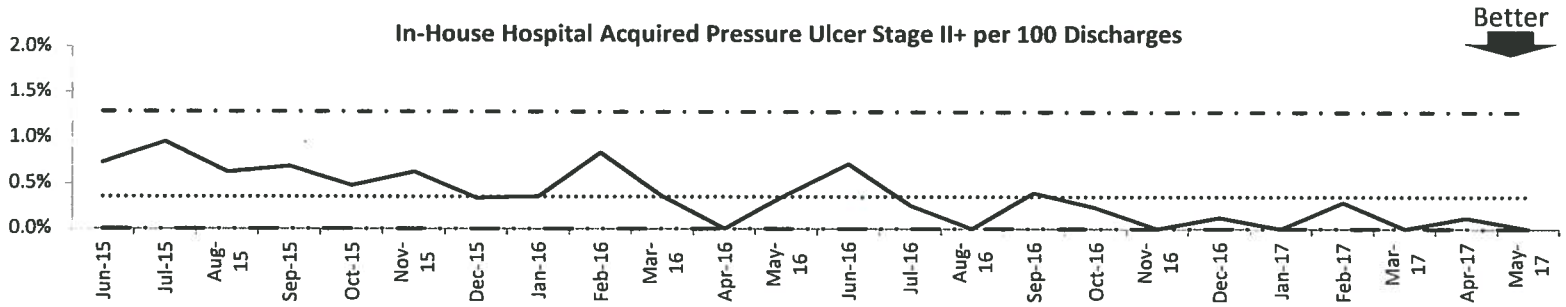
Current Trending Measures



Action Plan

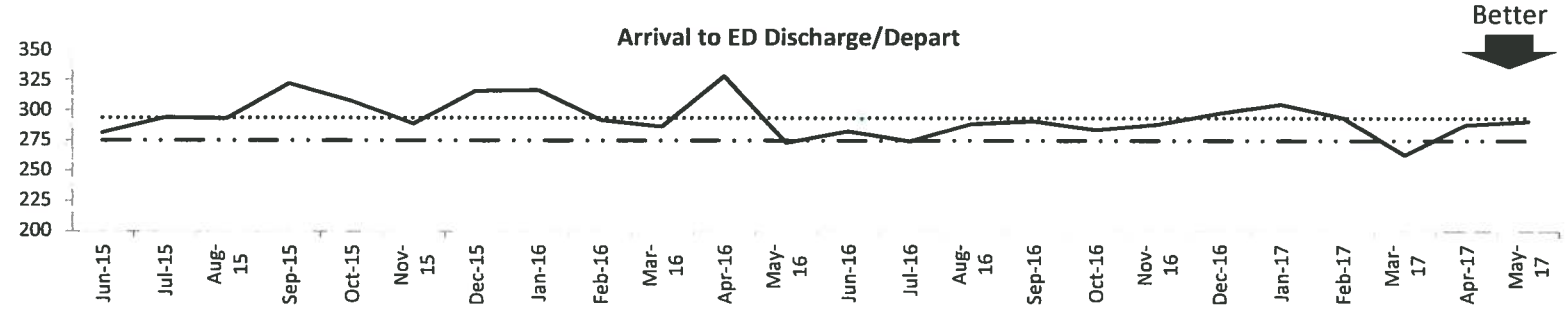
Goal to monitor & sustain improvements.
Toileting:
- Hourly rounding
- At risk assist to bathroom q. 4-6 hours.
- Remain in BR with high risk pts.
- Educate pt and family.

Redesign Fall Risk:
- "Fresh visibility"



Action Plan

> Incr Expert Staff & create zones for focused education.
> Staff educ revised classification of pressure injuries.
> 4 Eyes in 4 hours.
> Implemented pressure injury treatment plan.
> Hardwire EHR prevention protocols.
> Implemented unit based wound champions.



Action Plan

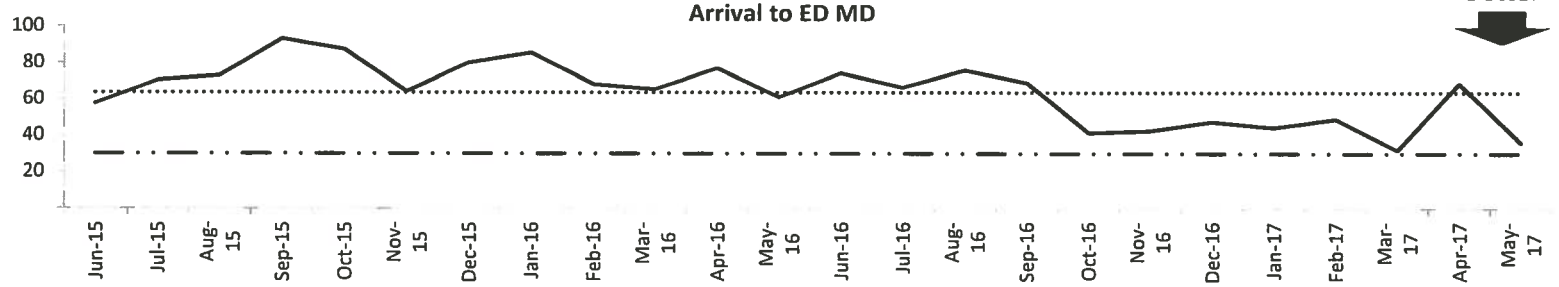
Time to discharge decreased by 40 minutes after adding MD to triage. < 240 minutes

Current Trending Measures

TCMC Rate ..... Mean - - - - CA Mean — · — · — TCMC Target

Better

Arrival to ED MD

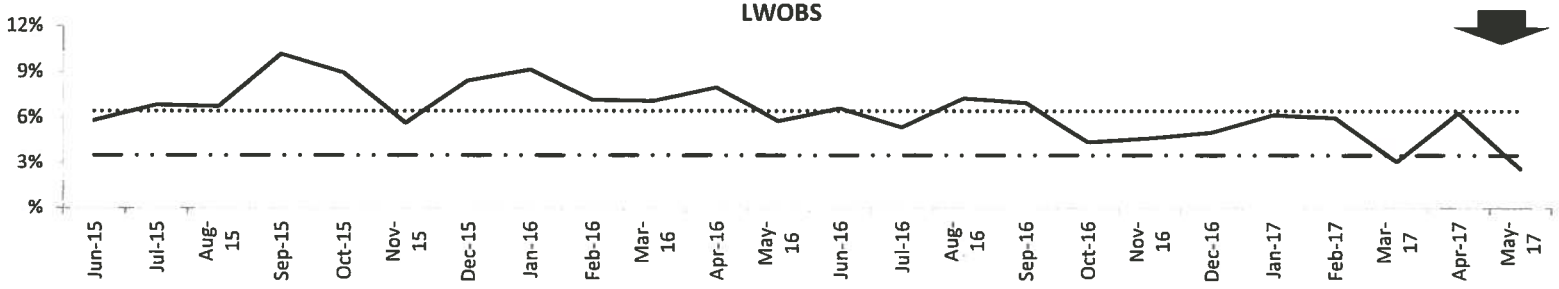


Action Plan

Arrival to MD/PA assessment 22 minutes

Better

LWOBS

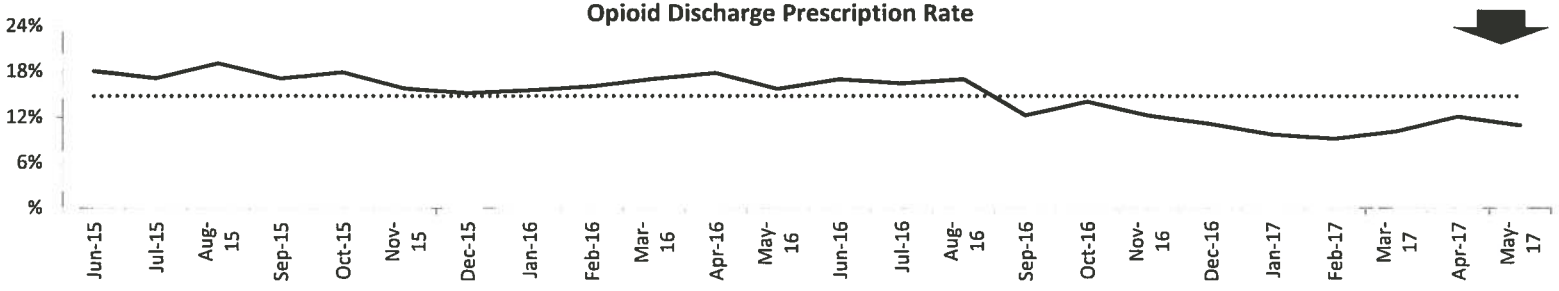


Action Plan

2016 LWOBS was 6.9%. Currently, LWOBS YTD 2.1% due mainly to increased MD presence in Traige.

Better

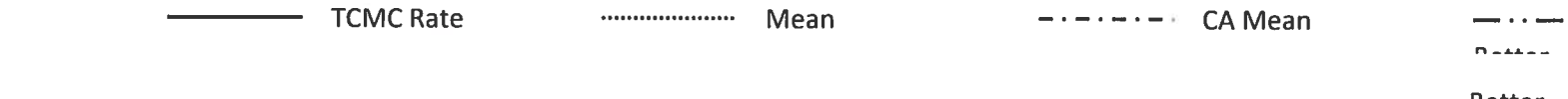
Opioid Discharge Prescription Rate

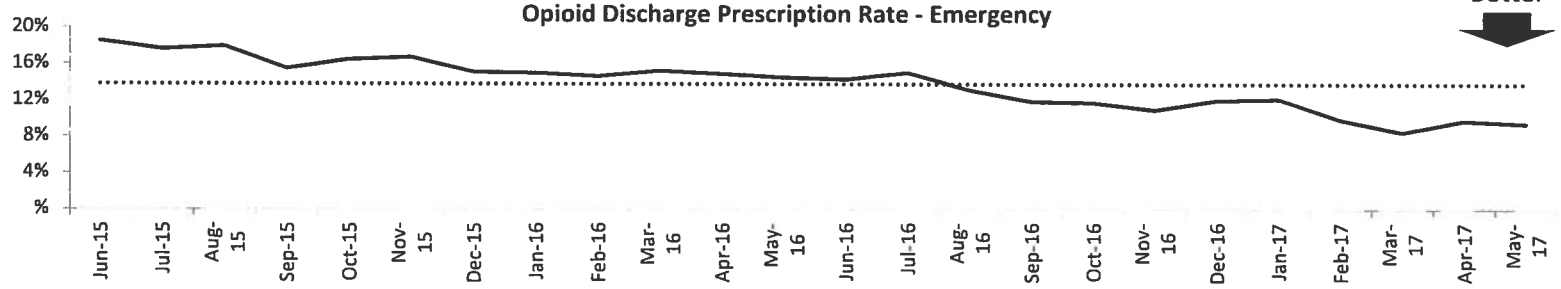


Action Plan

Continue to investigate the benefit of the use of CURES. Provide education to patients regarding the use of non-pharmacological methods for pain management and the risks vs benefits of opioid use. Continue to provide education to the physcians regarding opioid prescribing at time of discharge.

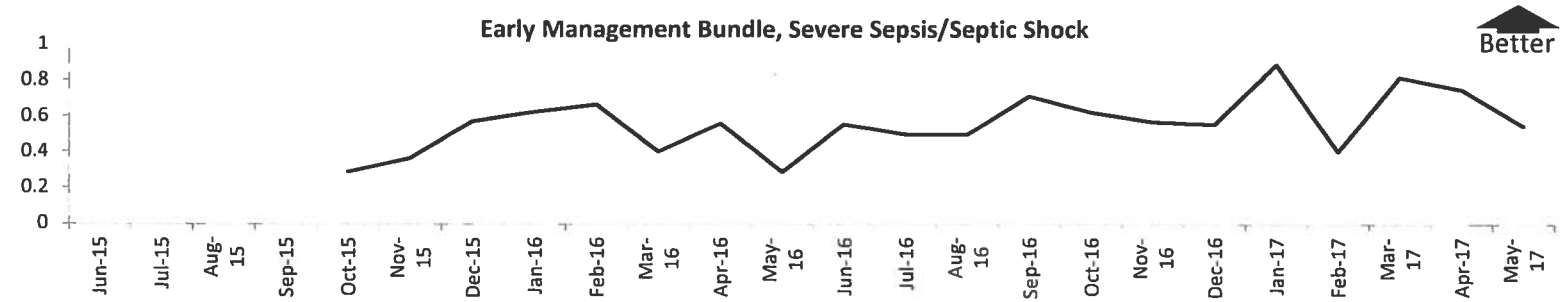
Current Trending Measures





Action Plan

Continue to evaluate the process of accessing CURES. Provide education to the patients regarding the use of non-pharmacological methods for pain management and the risks vs benefits of opioid use. Continue to provide education to the physicians regarding opioid prescribing at time of discharge.



Action Plan

Erratic results due to small sample size. 1st Quarter 2017 achieved 76% pass rate which met 70% goal. 2016 & TYD 2017 only 4 Severe Sep started after admission. None of these passed measure, current focus. Working in Cerner triggers and Code Sepsis process.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Volume

*June data to be updated in September

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	28	22	13	25	27	23	19	24	25	25	30		261
FY16	49	29	30	30	23	29	23	28	32	27	27	29	356

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	9	9	5	13	12	11	10	8	15	8	12		112
FY16	20	19	15	23	12	13	16	15	15	17	8	15	188

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	8	11	8	13	12	8	12	10	12	11	17		122
FY16	9	10	8	8	13	11	9	13	14	8	8	9	120

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	18	18	17	14	20	22	20	16	18	13	17		193
FY16	16	19	13	4	7	9	15	20	15	13	17	15	163

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	31	35	29	42	34	29	31	30	31	37	28		357
FY16	40	36	37	44	34	33	45	39	38	39	38	50	473

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1		16.0
FY16	19.9	19.6	17.6	18.0	16.0	16.7	17.5	15.5	15.2	14.5	15.3	17.6	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0		6.4
FY16	7.1	4.9	5.6	6.9	7.1	6.7	6.5	6.6	5.0	6.5	5.5	6.3	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0		14.1
FY16	13.3	11.1	14.3	15.1	16.3	19.0	20.1	16.3	13.5	16.0	17.1	13.4	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9		180.5
FY16	183.9	183.4	199.7	187.7	182.4	200.6	202.9	203.0	186.7	200.7	183.9	189.2	191.9

Performance compared to prior year: Better | Same | Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	223	239	274	230	197	200	217	197	202	172	188		2339
FY16	215	214	252	227	232	220	216	183	209	189	208	200	2565

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	12	11	12	16	11	14	15	11	6	15	12		135
FY16	16	9	19	12	16	10	11	15	15	15	18	12	168

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	4	4	6	6	5	7	2	2	7	9	6		58
FY16	7	3	7	4	5	7	6	6	6	4	2	7	64

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	10	9	8	7	6	9	8	6	16	9	6		94
FY16	7	14	4	6	7	10	2	8	13	12	5	7	95

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71		1.70
FY16	1.65	1.63	1.60	1.62	1.63	1.56	1.54	1.63	1.65	1.60	1.66	1.68	1.62

Performance compared to prior year: Better Same Worse

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

*June data to be updated in September

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	48.9	49.0	48.8	49.4	48.1		49.5	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	47.9	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	84.6	79.9	74.6	79.9	81.5		83.2	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	84.1	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	($226)	$181	($2,912)	($63)	$296		$371	$6,109
FY16	$862	$612	$182	($189)	($513)	$965	($1,784)	($411)	($220)	$331	$315	($1,842)	$149	

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%	-0.79%	0.67%	-9.92%	-0.22%	0.99%		0.12%	1.90%
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%	0.05%	

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	$1,010	$1,428	($1,630)	$1,213	$1,558		$14,305	$20,431
FY16	$2,046	$1,817	$1,357	$1,011	$644	$2,155	($594)	$797	$1,019	$1,530	$1,598	($558)	$13,379	

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%	3.52%	5.28%	-5.55%	4.23%	5.21%		4.61%	6.37%
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%	4.35%	

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	6.26	6.14	6.25	6.30	6.18		6.11	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	5.94	

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	1.35	1.37	1.51	1.32	1.35		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	$35.7	$34.6	$73.6	$74.3	$77.9		
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 FOR Y

Construction Report
As of June 2017

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
L&D and Mother Baby Renovation	December-16	100%	January-17	August-17	85%	1,191,590	966,635	224,955	24 rooms are completed. 4 rooms left for renovation.
Rebuild of Men's & Women's ADA Shower Stalls to Code at the Wellness Center	June-16	100%	December-16	June-17	100%	59,945	38,972	20,973	Project is completed.
Kitchen Sanitary Pipe Repairs	March-17	100%	February-17	April-17	100%	1,750,000	1,697,981	52,019	Project is completed.
OR #1 Surgical Lights Replacement	December-16	100%	September-17	October-17	0%	412,871	0	412,871	Lights are on order.
OR #2 Surgical Lights Replacement	February-17	100%	July-17	August-17	0%	365,828	0	365,828	Construction starting July 5th.
Total Construction Projects						**$3,780,234**	**$2,703,588**	**$1,076,646**	

*Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending June 30, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location
American Health & Retirement DBA: Vista Medical Plaza 140 Lomas Santa Fe Dr., Ste 103 Solona Beach, CA 92075 V#82904	1,558	$2.39	(a)	4,917.74	01/27/17	05/31/20	**Venus OBGYN Clinic** 2067 W. Vista Way, Ste 160 Vista, CA 92083
Camelot Investments, LLC 5800 Armada Dr., #200 Carlsbad, CA 92008 V#15608	Approx 3,563	$1.80	(a)	10,319.46	4/1/2016	01/31/20	**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	$2.63	(a)	20,106.00	2/1/2015	01/31/20	**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	06/30/17	**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)	10,013.17	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	$1.35	(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	$1.10	(a)	5,039.70	10/28/13	03/03/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Total				**$ 98,740.48**			

(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 6/30/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6183	AMERICAN SOCIETY OF ANESTHESIOLOGIST	52217	308.39	80084	COURTNEY NELSON
6183	AM SOCIETY OF ANESTHESIOLOGIST - AIRFARE	52517	790.40	59683	COURTNEY NELSON
7420	AM BOARD OF PERIANESTHESIA CERT	53017	552.17	82947	VANESSA VRIENS
7772	FACTURE CASTING AND BRACING SEMINAR	51817	200.00	78951	CARLYN WAGNER
7772	HAWKGRIPS COURSE	33117	319.65	82982	NICK YEARBY
7894	INS ANNUAL MEETING	52317	1,793.47	80734	RENATA MACIK
8390	CHA MED SAFETY MEETING	22817	238.47	81328	THERESA VIDALS
8480	CISO CONFERENCE	52517	480.13	81393	ROBERT FLORES
8610	AHA AND CA PAC MEETING - AIRFARE	53117	200.00	81163	STEVEN DIETLIN
8610	DHLF MEETING - EXPENSES	52217	991.31	81508	STEVEN DIETLIN
8610	DHLF MEETING - HOTEL	53117	615.48	81163	STEVEN DIETLIN
8610	DHLF MEETING - AIRFARE	53117	635.96	81163	STEVEN DIETLIN
8618	IMAGINE SOFTWARE SEMINAR	60617	219.78	46515	MELISSA NAIL
8620	AHA AND CA PAC MEETING - AIRFARE	53117	200.00	81163	JAMES DAGOSTINO
8620	AHA AND CA PAC MEETING - EXPENSES	52317	1,550.55	81515	JAMES DAGOSTINO
8620	AHA MEETING - EXPENSES	52517EXP	1,996.83	78591	LARRY W. SCHALLOCK
8620	SACRAMENTO - EXPENSES	62717	105.99	23274	TERI DONNELLAN
8710	CAMSS ANNUAL EDUCATION FORUM	42417	926.53	81103	SHIRLENE TAYLOR
8740	CANCER BASICS COURSE	60117	200.00	82992	ALLISON MESHAKO
8740	ASSOCIATES DEGREE NURSING	60117	1,346.02	82990	AMANDA MAUHILI
8740	ASSOCIATES DEGREE NURSING	60117	1,105.39	81980	AMBER BOUGE
8740	BACHELORS OF SCIENCE NURSING	61317	2,500.00	83000	APRIL SOLIMAN
8740	ASSOCIATES DEGREE NURSING	60817	801.88	82610	CHARLINE TARR
8740	BACHELORS OF SCIENCE NURSING	62217	2,500.00	82065	CHRISTIN SANTA MARIA
8740	BACHELORS OF SCIENCE NURSING	62917	2,500.00	77804	DEBBIE ENGELHART
8740	NRP INSTRUCTOR COURSE	60817	149.00	82703	DONNA WHEATON
8740	LACTATION COUNSELOR TRAINING	60817	200.00	82988	ELEATA DONALSON
8740	NRP INSTRUCTOR COURSE	60117	149.00	80572	ELIZABETH FLEMING
8740	ASSOCIATES DEGREE NURSING	60117	1,108.81	82738	FATIMA FAYE SATULAN
8740	MASTERS DEGREE PROGRAM	60117	2,000.00	82991	JACQUELINE FRITTS
8740	911 CONFERENCE	61317	105.00	77983	JULIE MATTISON
8740	MSN COURSE	60917	5,000.00	82987	LAYNA WILLIAMS
8740	MASTERS IN HEALTCARE	60117	5,000.00	82419	LORI ROACH
8740	BACHELORS OF SCIENCE NURSING	60117	2,500.00	82989	RICHELLE ASHTEN TUCK
8740	BACHELORS OF SCIENCE NURSING	62217	2,000.00	83001	RYAN FERNANDEZ
8740	CANCER BASICS COURSE	60117	189.00	82993	SARAH MATA
8750	HEALTHCARE LAW & COMPLIANCE INSTITUTE	62917 GA	1,070.24	82462	CHERYLE BERNARD-SHAW
8750	CA SOCIETY OF HEALTHCARE ATTY	62617 CA	1,562.20	82462	CHERYLE BERNARD-SHAW

**This report shows 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.