TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
September 28, 2017 – 1:30 o'clock p.m.
Assembly Room 1 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 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. Approval of prior Closed Session Minutes 1) Regular Board of Directors Meeting – August 31, 2017 2) Special Board of Directors Meeting – September 7, 2017		
	d Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 1 Matter)		
	e. Evaluation of Legal Counsel Services (Authority: Gov. Code section 54957)		
7	Motion to go into Open Session		
8	Open Session		

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
	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	Introduction – Carlos Cruz, Chief Compliance Officer	3 min.	CEO
13	Special Presentation – 1) Presentation of Patient Satisfaction Award to Emergency Department 2) Presentation of Certificate of Appreciation to Jack Cumming for his participation on the Audit, Compliance & Ethics Committee	 5 min. 5 min.	 CNE Director Schallock/ ACE Comm.
14	Report from TCHD Auxiliary – Mary Gleisberg, President	5 min.	
15	Report from Chief Executive Officer	10 min.	Standard
16	Report from Acting Chief Financial Officer	10 min.	Standard
17	New Business		
	a. Consideration to accept the FY2017 Financial Statement Audit b. Public Hearing Regarding Change from At Large to District Based Election - Elections Code §10010(a)(1) *Pursuant to Elections Code Section 10010(a)(1), before drawing a draft map or maps of the proposed boundaries of the districts, the political subdivision shall hold at least two public hearings over a period of no more than thirty days at which the public is invited to provide input regarding the composition of the districts* c. Consideration of Resolution No. 789, A Resolution of the Tri-City Healthcare District Board of Director in Support of *Live Well San Diego* Initiative	15 min. 30 min. 5 min.	Moss Adams/ACE Committee Doug Johnson/ General Counsel CMO
18	Old Business a. Update on LAFCO Application/Annexations	 10 min.	 General Counsel
	b. Update on Board Portal	5 min.	Director Mitchell

	Agenda Item	Time Allotted	Requestor
	c. Board Retreat Follow-up 1. Consideration to direct Grant Ad Hoc committee to make recommendation to the Board regarding the Grant Program at the December Regular Meeting 2. Consideration to direct Administration to make recommendation to the Board on ways to strengthen support as outlined in Governance Enhancement Plan. 3. Consideration to direct Board Committee Chairs to make recommendation to Board at the October meeting regarding committee composition and meeting frequency. 4. Consideration to add standard 15 minute Educational Session to every Regular Board Agenda beginning with the October Board meeting. 5. Consideration to direct Board Chair to solicit professional presentation on reimbursement to enhance the Board's financial literacy and present in 2017.	30 min.	Chair
19	Chief of Staff a. Consideration of September 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on September 25, 2017 b. AHP Nurse Practitioner – Interventional Radiology Standardized Procedures	5 min.	Standard
20	Consideration of Consent Calendar (1) Board Committees ***(1) All Committee Chairs will make an oral report to the Board regarding items being recommended if listed as New Business or pulled from Consent Calendar.*** ***(2) All items listed were recommended by the Committee.*** ***(3) Requested items to be pulled require a second.*** **A. Human Resources Committee** Director Kellett, Committee Chair Open Community Seats – 0 (Committee minutes included in Board Agenda packets for informational purposes) 1. Approval of Gwen Sanders to an additional two-year term on the Human Resource Committee 2. Approval of Administrative Policies & Procedures: a) Alcohol & Drug Testing for Employees – 429 b) Employee Transfers – 432 c) Conflict of interest Acceptance of Gifts - 483	5 min.	Standard HR Comm.

	Agenda Item	Time Allotted	Requestor
	B. Employee Fiduciary Retirement Subcommittee Director Kellett, Subcommittee Chair Open Community Seats – 1 *(Committee minutes included in Board Agenda packets for informational purposes)*		Emp. Fid. Subcomm.
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair Open (*Committee minutes included in Board Agenda packets for informational purposes)Community Seats – 2*		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)*		FO&P Comm.
	1) Approval of the renewal of a renewal of an agreement with Infor US, Inc. for multi-year support commitment for Lawson systems to include time management, payroll, accounts payable and general ledger for a term of 36 months, beginning June 1, 2017 through May 31, 2020 for a total cost for the term of $893,325.		
	2) Approval of a renewal of a Primary Medical Supply Distribution Agreement with Cardinal Health 200, LLC for a term of 60 months, beginning October 1, 2017 through September 30, 2022, for an annual spend of $10,800,000 and a total spend for the term of $54,000,000.		
	3) Approval of the addition of Dr. Pargol Samani to the Emergency Department On-Call Panel for Cardiology-General for a term of 12 months, beginning October 1, 2017 through September 30, 2018.		
	4) Approval of an agreement with ETC Building & Design for $99,955 and the purchase of equipment to replace the lights in operating room #4, for a total expected project cost of $510,761,27.		
	5) Approval of an agreement with Good-Men Roofing and Construction, Inc. for $284,348 and a project budget increase of $37,132 to the previously board approved budget of $336,161 in June 2017 for a total cost of $373,293 for the construction of a Retail Pharmacy		
	6) Approval of an agreement with Good-Men Roofing & Construction, Inc. for $208,828 and a total project budget of $295,482 for construction of a Seclusion Room in the Behavioral Health Unit.		
	7) Approval of an agreement with Dr. Gehaan D'Souza as the Plastics Coverage Physician for a term of 12 months beginning October 1, 2017 through September 30, 2018, for a total cost for the term of $100,000.		

	Agenda Item	Time Allotted	Requestor
	8) Approval of an agreement to Dr. Bilal Choudry, Neuroscience Health Institute – Operations Committee member for a term of 12 months, beginning September 1, 2017 through August 31, 2018, not to exceed an average of two hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040 and a total cost for the term of $5,040. 9) Approval of an agreement with Dr. Bilal Choudry, Neuroscience Health Institute – Quality Committee member for a term of 12 months, beginning September 1, 2017 through August 31, 2018, not to exceed an average of two hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040. 10) Approval of an agreement with Dr. Paul Sarkaria, Cardiovascular Health Institute - Operations Committee member for a term of 12 months, beginning September 1, 2017 through August 31, 2018, not to exceed an average of two hours per month or 24 months annually, at an hourly rate of $210 for an annual cost of $5,040 and a total cost for the term of $5,040. 11) Approval of an agreement with Dr. Mohammad Jamshidi-Nezhad, Specialty Medical Director for Vascular Surgery for a term of 12 months, beginning July 1, 2017 through June 30, 2018, not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual cost of $30,240, and a total cost for the term of $30,240. 12) Approval of a First Amendment Lease Renewal option for Tri-City Medical Center with Norman Levitt/Levitt Family Trust for an additional two-year term, beginning September 1, 2017 through August 31, 2019, at a total cost not to exceed $253,748. 13) Approval of an agreement with Coastal Hospitalists Medical Associates, Inc. for On-Site Coverage Services Agreement beginning September 1, 2017 through June 30, 2019, at a monthly cost of $217,917, an annual cost of $2,615,004 plus an educational allowance up to $10,000 per year and a total cost of $4,814174, for the term.		
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)* **1) <u>Patient Care Policies and Procedures</u>** a) Bed Utilization, Demand Greater than Capacity Policy-Tracked Changes Bed Utilization, Demand Greater than Capacity Policy b) Blood Products Administration Procedure c) Chain of Command Policy d) Hand Off Communication Policy e) Nursing Chain of Command Policy (DELETE)		PAC

	Agenda Item	Time Allotted	Requestor
	f) Plan for Nursing Care g) Rigid Laryngscope Reprocessing Procedure h) Skin Preparation, Surgical Procedural Policy i) Universal Protocol Procedure **2) <u>Administrative Policies & Procedures</u>** a) Mandatory Reporting Requirements b) Policy Approval- Administrative **3) <u>Unit Specific – Behavioral Health Services</u>** a) Abuse Reporting Forms **4) <u>Unit Specific – Education</u>** a) AHA: Non-TCHD Class Participants b) Description of professional Education department c) Inservice Education Policy d) Mission and Vision of the Education Department Policy **5) <u>Unit Specific – Medical Staff</u>** a) Election Process of Member(s)at Large for MEC **6) <u>Unit Specific – Outpatient Behavioral Health</u>** a) Admission to Inpatient Behavioral Health Unit b) Age Appropriate Care c) Communications (DELETE) d) Solicitation of Patients / Referral to Self (DELETE) e) Substance Abuse f) Suicide Assessment **7) <u>Unit Specific - Outpatient Infusion Center</u>** a) Adverse Reaction- Medication Event b) Central Venous Access Devices, Adult (DELETE) c) Hospital Admission from the Center d) Outpatient Summary List Procedure (DELETE) e) Patient Discharge f) Physician Orders/ Request for Services **8) <u>Unit Specific – Pharmacy</u>** a) Transdermal Fentanyl Patch Prescribing and Use **9) <u>Unit Specific – Pulmonary</u>** a) Pulmonary Scope of Services b) Respiratory Medication Administration **10) <u>Unit Specific – Rehabilitation</u>** a) Emergency Care Outpatient Services b) Movies, Videos (DELETE) **11) <u>Pre-Printed Orders</u>** a) Cardiac Cath Lab Medication Orders b) Cardiac Rehabilitation Physician Referral orders c) OB Scheduled C-Section Orders		

	Agenda Item	Time Allotted	Requestor
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 1 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of Board Policy 14-001 – Budget for medical Equipment or Medical Services for Tri-City Healthcare District 2) Approval of amended Bylaws **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes)* **1) <u>Approval of Administrative Policies & Procedures</u>:** 1. Employee Response to Government Investigation 2. Advanced Beneficiary Notice (2) Minutes – Approval of: a) Regular Board of Directors Meeting – July 27, 2017 b) Special Board of Directors Meeting – August 1, 2017 (3) Meetings and Conferences – NONE (4) Dues and Memberships - a) Trustee Magazine Subscription - $472.00		Audit, Comp. & Ethics Comm. Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (August, 2017) (d) Reimbursement Disclosure Report – (August, 2017) (e) Seminar/Conference Reports 1) ACHD Annual Meeting – Director Dagostino	0-5 min.	Standard
23	Legislative Update	5 min.	Standard
24	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
25	Additional Comments by Chief Executive Officer	5 min.	Standard
26	Board Communications (three minutes per Board member)	18 min.	Standard
27	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3.5 hours	

	Agenda Item	Time Allotted	Requestor
28	Oral Announcement of Items to be Discussed During Closed Session		
29	Motion to Return to Closed Session (if needed)		
30	Open Session		
31	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
32	Adjournment		

AUDIT MATERIALS AVAILABLE UPON REQUEST

RESOLUTION NO. 789

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE TRI-CITY HEALTH CARE DISTRICT IN SUPPORT OF LIVE WELL SAN DIEGO INITIATIVE

WHEREAS, the mission of Tri-City Medical Center is to Advance the Health and Wellness of the Communities We Serve;

WHEREAS, Tri-City Medical Center recognizes the importance of Live Well, San Diego's vision of a region that is Building Better Health, Living Safely and Thriving, as adopted by the San Diego County Board of Supervisors in 2010; and

NOW THEREFORE, BE IT RESOLVED: Tri-City Medical Center affirms our support of the Live Well, San Diego initiative.

PASSED AND ADOPTED on this ____ day of September, 2017 by the following vote:

AYES:	**DIRECTORS:**
NOES:	**DIRECTORS:**
ABSENT:	**DIRECTORS:**
ABSTENTIONS:	**DIRECTORS:**

TRI-CITY HEALTH CARE DISTRICT

By: _____
Chair of the Board of Directors

Attest:

By:_____
Laura E. Mitchell, Secretary

LIVE WELL SAN DIEGO

WHAT IT IS

The County of San Diego's vision of a region that is Building Better Health, Living Safely and Thriving

BUILDING BETTER HEALTH

Improving the health of residents and supporting healthy choices

LIVING SAFELY

Ensuring residents are protected from crime and abuse, neighborhoods are safe, and communities are resilient to disasters and emergencies

THRIVING

Cultivating opportunities for all people and communities to grow, connect and enjoy the highest quality of life

In 2010, the County Board of Supervisors adopted the *Live Well San Diego* vision of a region of 3.2 million residents that is Building Better Health, Living Safely and Thriving. Based upon a foundation of community involvement, *Live Well San Diego* includes three components: *Building Better Health*, adopted on July 13, 2010; *Living Safely*, adopted on October 9, 2012; and *Thriving*, adopted on October 21, 2014.

Live Well San Diego is built on four strategic approaches:

1. BUILDING A BETTER SERVICE DELIVERY SYSTEM

Improve the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities

2. SUPPORTING POSITIVE CHOICES

Provide information and resources to inspire county residents to take action and responsibility for their health, safety and well-being

3. PURSUING POLICY & ENVIRONMENTAL CHANGES

Create environments and adopt policies that make it easier for everyone to live well, and encourage individuals to get involved in improving their communities

4. IMPROVING THE CULTURE WITHIN

Increase understanding among County employees and providers about what it means to live well and the role that all employees play in helping county residents live well

PROGRESS THROUGH PARTNERSHIPS

Live Well San Diego involves everyone. Only through collective effort can meaningful change be realized in a region as large and diverse as San Diego County. The County's partners include cities and tribal governments; diverse businesses, including healthcare and technology; military and veterans organizations; schools; and community and faith-based organizations. Most importantly, *Live Well San Diego* is about empowering residents to take positive actions for their own health, safety and well-being.

Every County department is committed to playing an active role and coordinating efforts to make the biggest impact. Annual reports highlight success stories of local communities, organizations and recognized partners who are making positive changes. These reports can be accessed on the *Live Well San Diego* website at **LiveWellSD.org/about/live-well-san-diego-materials/**. This website also includes resources for getting involved; best practice tools for organizations and recognized partners in every sector; and information about the *Live Well San Diego* Indicators, which measure our region's collective progress.

RESULTS

How will progress be measured? The Top Ten *Live Well San Diego* Indicators have been identified to capture the overall well-being of residents in the county. These Indicators are part of a framework that allows the County to connect a wide array of programs and activities to measureable improvements in the health, safety and well-being of every resident. The complete framework is posted on the County of San Diego *Live Well San Diego* webpage: http://sdcounty.ca.gov/content/sdc/live_well_san_diego/indicators.html

HEALTH

Life Expectancy

Quality of Life

KNOWLEDGE

Education

STANDARD OF LIVING

Unemployment Rate

Income

COMMUNITY

Security

Physical Environment

Built Environment

SOCIAL

Vulnerable Populations

Community Involvement

September, 19, 2017

Proposal for action plan, Governance Enhancement Plan James Rice 9/7/2017 Submitted by James Dagostino, Board Chair

The board has been presented a governance enhancement plan outlined by James Rice based on insights from our board workshop on September 7, 2017. Mr. Rice has outlined five areas that need some attention.

First and most important**, Does the board agree with Mr. Rice's assessment?** This should be debated today and we should come at a decision. Assuming we agree with some or all of the categories, I summarized by category how to start the action plan.

Expanded Community Linkages

The grants program points to issues that the board is already identified. We have created an ad hoc committee comprised of Directors Nygaard, Schallock and Grasse. The committee has had their first meeting and has started work on this program.

The community relations and marketing strategies were also identified as needing some actions.

Proposal- The ad hoc committee continues to work on the grant process and make recommendations to the board no later than November 2017. Also the ad hoc committee will work with the CEO and Marketing Director work on the 16 items identified by Mr. Rice.

Strengthen Physician Support

12 items were identified under this category. Most unique is the hiring of a Chief Medical Officer (CMO) as a member of senior management to work more smoothly with our medical staff. The recommendation was also made have nurses and physicians continually update board members which may come in the form of presentations at board meetings. The third major issue was organizing more physician appreciation events and it was suggested that that may have to be organized through The Foundation.

Proposal- An Administration Champion, Chief of Staff and a Board member work to make recommendations to the Board Member about implementation of some of the recommendations by December 2017.

Increased Meetings' Return on Invested Time and Talents

This is been one of the most challenging areas this board has ever debated. We consistently run up against the demands of the Brown Act, District Law, as well as our tradition. The first question that needs to be decided today is**, are we willing to change? The second question is, are we willing to**

decrease the size of our committees? If the answer is a resounding yes by this board then I think we need to start taking some action today.

Proposal - Committee chairs will seek information about limiting the size of their committee. The committee chair shall talk to medical staff, administration and nursing regarding who needs to attend each committee meeting and those who do not need to be there.

Proposal - Reduce the size of each committee by one community member. This can be done by attrition so that when a member's reappointment is due we will not reappoint that position.

Proposal - Expedite the implementation of the board portal and commit to having it up and running by December 2017

Enhanced Board Development from Intentional Education Initiatives

Most of the recommendations made by Mr. Rice involve consistent board education at almost every board meeting. He talks about field trips and interior and exterior professional presentations. His recommendations suggest 15 minute presentations at board meetings and organized education sessions that have defined time limits. He has listed categories that may be of interest to the board.

Proposal- Add to each board agenda 15 minute educational sessions for the remainder of the 2017 board meetings. Assess the productivity of the sessions and adjust in 2018.

Enhanced Financial Literacy

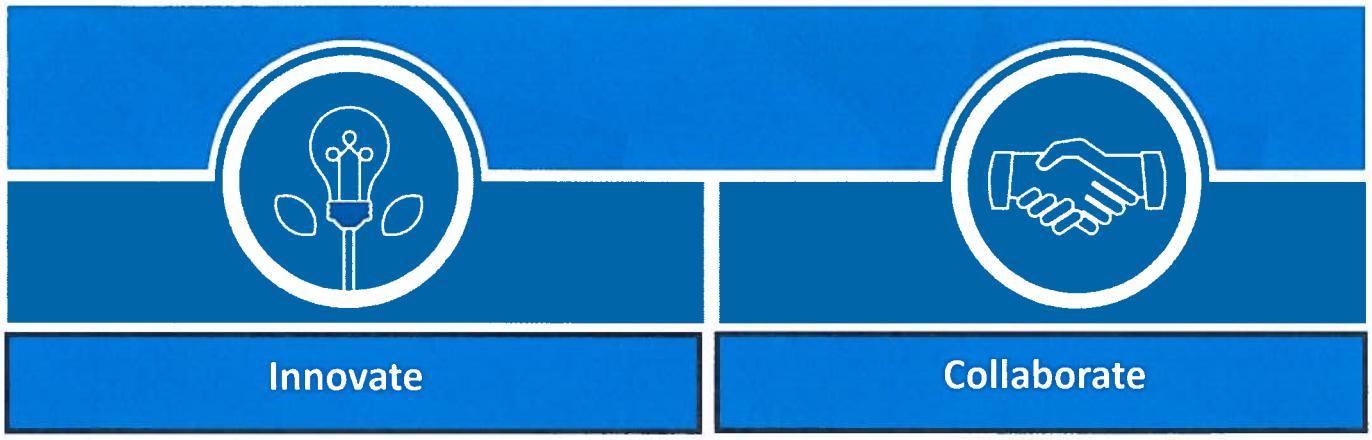
Our board has been consistently frustrated with their lack of financial knowledge. We all come from different backgrounds but even those of us in healthcare have difficulty understanding how our hospital gets reimbursed for the services we provide. This financial literacy is a process that we ought to start and it may be a part of our education series.

Proposal- Solicit professional presentation on reimbursement that is understandable to a lay public. Add this to the board agenda in 2017 and then let the board direct what other types of "pullout education programs "we might need

Governance Enhancement Plan:

Actions to go from Strength to Strength 2018-2020

Tri-City Medical Center



Retreat Insights from Tri-City Medical Center Governing Board
September 7, 2017

James A. Rice, Ph.D.
Managing Director, Governance & Leadership
Gallagher Integrated
A Division of Arthur J. Gallagher
Jim_rice@ajg.com

Preface

This Guide is designed to help ensure follow-through and follow-up on a series of practical initiatives from the Governance Enhancement Retreat by the Board and Leadership Team of Tri-City Medical Center.

Small and large group discussions during the retreat built from a review of the Tri-City Board Self-Assessment Report developed in conjunction with the Association of California Health Districts (see: http://www.achd.org/) and as facilitated by Jim Rice of Gallagher Integrated, see: http://www.integratedhealthcarestrategies.com/About/Bio/james-a-rice.

The results from the 2017 Board Self-Assessment indicated that the Tri-City Board has made substantial positive progress in advancing its capacity for wise governance of the valued hospital system focused at the Tri-City Medical Center based in Oceanside California, see: https://www.tricitymed.org/about-us/Board-of-directors/

The seven Board Members assessed the Board's overall performance in ten leadership areas, including:

- Mission, values and vision;
- Strategic direction;
- Leadership structure and processes;
- Quality and patient safety;
- Community relationships;
- Relationship with the CEO;
- Relationships with the medical staff;
- Financial leadership;
- Community health; and
- Organizational ethics.

Board members rated 167 total criteria in these ten areas. The survey results indicate the Board has improved its performance scores in a majority of these criteria.

Five areas in which the Board and Executive Team exchanged ideas about how to further enhance the work of the governing Board are:

1. Expanded Community Linkages
2. Strengthened Physician Support
3. Increased Meetings' Returns on Invested Time and Talents
4. Enriched Board Development from Intentional Educational Initiatives
5. Enhanced Financial Literacy

This document provides a summary of the several actions that the Board and senior leadership team intend to accomplish in calendar year 2018.

Expanded Community Linkages

Participants in the Governance Review provided several proposed actions as a means to expand and enhance the working relationships and influence of the Tri-City Board and System with a variety of community stakeholder groups in and around the main communities of the North County Health District (San Diego County's coastal communities of Carlsbad, Oceanside and Vista), including such varied organizations as:

- School districts
- Chambers of Commerce
- Live Well San Diego
- Boys and Girls Clubs
- Economic Development groups
- Community Inter-Faith Organizations
- UCSD and its network of care providers
- Local political leaders
- Media Organizations

An important focus of the discussion was on the "**Community Grants Program**" of the Tri-City Medical Center (TCMC), but as positioned within a broader context of community and marketing programs underway throughout the organization, such as:

- Creative market research and listening efforts throughout the TCMC region among diverse community groups, vulnerable populations, and potential patient user groups
- Community outreach by the TCMC Foundation
- Marketing and Public Relations Communication Strategies
- Marketing and payer contracting for service line relationships with payers and employers in the TCMC region

The Community Grants Program was studied as to its future strategic value; factors that may get in the way of its future success; and actions that could enhance its future effectiveness for the people of the region, as well as for the strategic plans of TCMC. A summary of conclusions regarding these issues is outlined below:

Value of the Grants Program: This initiative is seen as an important investment of approximately $300,000 per year by TCMC to support community organizations that contribute to the health and well-being of the TCMC District. The programs supported by the grants programs in the future should help demonstrably and tangibly contribute to these criteria:

- Protect and promote the health of vulnerable populations in the region
- Support respected community organizations that are aligned with the strategic mission and plans of TCMC, and will leverage the ROI of our grants with other community resources
- Enhance the effectiveness and vitality of community organizations that can meaningfully support the well-being of the people and growth of The TCMC District

Factors that Could Frustrate Success: The program has evolved from its early beginnings over 20 years ago under valued leadership of community volunteers from the TCMC District. The governance of the grants program, now however, is ready for refinements to help ensure its alignment with TCMC and optimal impact for people within the District. The links to TCMC Board, executives and plans has become uncertain. Community and media awareness of the programs and its past results is underdeveloped.

There is a need for stronger communications of its existence, priorities, plans and measurable results. Accountability and transparency of the grant programs can be enhanced in the coming year.

Actions to Enhance Impact of the Grants Program: Draft strategies that were identified for further discussion and prioritization are:

- Reconstitute the "Grants Governance Council" to be chaired by a TCMC Board member with careful recruiting, onBoarding and development of additional new members. All members to have a "position description", a conflicts of interest policy, and term limits (perhaps 2 or 3 three year teams). Members might be drawn from various community health promotion groups, Chambers of Commerce, Livewell San Diego (see: http://www.livewellsd.org/)
- Develop new "Policy Framework" similar to bylaws that explain the mission, plans, criteria to secure grants, and the process/conduct of decision-making by the Community Grants Governance Council to issue grants
- Develop a strategic plan that builds off the heritage of the program, is driven by an updated "Community Health Needs Assessment" in the TCMC District, and aligns it more closely with the mission and plans of the TCMC, and even the Foundation of TCMC
- Develop updated communication plans that celebrate the plans, work and results for the Grants across the district and with the media
- Develop more explicit contracts/agreements with grant recipients about their plans and accountability to show and report results
- Standardize the size and equity of grants to community partner organizations that can leverage the grants to broader and more sustained health gains
- Provide periodic reports from grant progress that impact the full TCMC Board and Community at large

Community Relations and Marketing Strategies for Board Engagement and Leadership:

Participants encourage the Board to consider these actions for the future vitality of TCMC community linkages, image and brand development:

1. Board needs to Commit for the ongoing assessment of the impact and ROI on all marketing, PR, advertising and communication programs
2. Board should be a key champion for our TCMC "Culture for Service Excellence from the Top"
3. Develop an updated "Strategic Marketing and Brand Development Plan" that aligns with the Strategic Business and Financial plans for TCMC
4. Communication plans are fact and data based/driven to build support for TCMC services and programs, as well as philanthropic support for our programs and partnerships
5. Coordinate communications and marketing with the Foundation and Grants initiatives
6. Encourage Board members to sign up for community events and go with staff to celebrate messaging to targeted community groups, events and activities
7. Study feasibility of 2-3 types of "Community Advisory Councils" to broaden our relationships and inputs to our plans and results
8. Support development of our 2200 employees as our best ambassadors to the communities we exist to serve. This should include a culture of appreciation from the Board for all the work they do for the people we serve
9. Consider media training for our Board, Executive and Physician Leaders
10. Weave positive performance and momentum that is now evident across TCMC into all of our messaging, especially to show we are good stewards of the community and government's money, and our quality and patient safety represents excellent value for their willingness to entrust their care to us
11. Be more intentional in nurturing community partnerships that promote healthy communities and people and employees working across the region (like our work with Livewell San Diego)
12. Ensure we continue to put a human face on what we do for real patients by real care givers and service providers
13. Study how Orange County providers are doing their community linkages,
14. Enhance our co-branding with our local and UCSD providers and programs
15. Leverage our social media tools

16. Others?

Strengthened Physician Support

Participants in the Governance Retreat recognize the value of strengthening our relationships with our many physician colleagues and partners. The following initiatives are suggested for further refinement by the Board and Executives of TCMC, (perhaps under the auspices of the Governance Committee and the MEC?):

1. Continue to support and enhance our reliance on the MEC to link Board, physician and management leaders for joint planning, coordination, and collaboration to strengthen TCMC performance
2. Study the feasibility of hiring a Chief Medical Officer (CMO) as member of our Senior Management to help champion and guide our partnering and alignment with physicians and their practices
3. Continue to invest in making available great technologies, facilities, staff and appreciation for physicians
4. Do more joint strategic and financial planning together
5. Invite physician leaders to carefully planned interactions within selected Board meetings
6. Arrange more social interactions and mixers
7. Engage physicians and nurses to continually educate Board members on the challenges of service delivery, quality of care, and patient safety
8. Invest in physician engagement and satisfaction studies
9. Organize more physician appreciation events and programming with Board thank you's
10. Feature physicians in our program marketing
11. Study how other organizations are using medical directorships to engage and align with our physicians as partners and colleagues
12. Improve our communications with physicians so they know we care about keeping them informed and supported by our work
13. Others?

Increased Meetings' Returns on Invested Time and Talents

Participants acknowledge that we meet too often and consume a great deal of time from the Board and Managers. We need to carefully study every meeting to be sure it is essential, the agenda is smart, the materials needed for decision-making are easy to understand and not overpowering. Other actions to consider are:

1. Seek help from the Association of California Health Districts to explore new flexibility in interpreting constraints of the Brown Act, for example only meeting six times with a normal agenda and using the other meetings for education, planning and partnership collaborations.
2. Make sure that we adopt a moving 18 month calendar of "Themed Meetings" so we as Board Members and our Executive team can plan for deeper dives into key topics and issues
3. Make sure every Committee or sub-group has a written charge, an annual work plan, and defined membership and guests.
4. Develop and maintain a running tally of the hours we invest into meetings, and ask if we are getting the ROI we need
5. Continue to use consent agenda to sharpen our focus and time efficiencies
6. Try to move more committees to quarterly meetings

7. Explore how a Board Member "Portal" or intranet can make it easier for us to track work and agendas of committees, and our works as a Board. Our Board packets are getting too big to print.
8. Others?

Enriched Board Development from Intentional Educational Initiatives

The Board is committed to continuously enrich and expand its access to and use for modern educational programming and materials. Suggestions from the retreat include:

1. Enhance our new Board Member orientation program, and include a mentoring program
2. Build 15 minute "educational insights" in at least three of our Board meetings each year. The "faculty" for these mini-sessions could be our managers, physicians, nurses, Allied Health staff, patients, or outside speakers
3. Study state of the art multi-media Board education programs
4. Consider "Study Tours" to other hospital systems in state or neighboring states
5. Encourage staff and Board member attendance at targeted educational programs by State and National Hospital Board conferences
6. Poll each Board member to define their priority topics for future education opportunities
7. Collaborate with others for quarterly "webinars" with ACHD, California Hospital Association, or even Orange County provider systems
8. Consider speakers brought into occasional joint meeting with physicians and nurses
9. Conduct poll to prioritize Board needs for "refresher" sessions on such topics as:
    - Health economics
    - Population health
    - The economic value of our payroll for over 2200 employees in the region
    - Bundled payments
    - Patient safety
    - New facility designs
    - Clinical care pathway designs
    - Others?
10. Expect all Board members that attend educational programs to share insights and ideas with the full Board
11. Others?

Enhanced Financial Literacy

The 2017 Board Self-Assessment identified a hunger from several Board members to better understand the challenging and complex arena of health industry financing, and the new value based payments.

Questions that are bubbling up are:

- How are we being paid now, what are our source or revenues?
- With our debt refinancing, how much are we saving the community in interest?
- What are our costs and sources of revenue by service and department?
- How are we going to be paid in the future?
- What does a Board member really need to understand for us to develop strategic fiscal performance targets, and to monitor our progress toward our financial targets?

- What are the essential 3-5 financial performance ratios we need to track, how are they developed and what factors influence their changes?
- How does our cost per units of service like admission compare to competitive hospitals in the region?

We should be a bit more intentional in developing our financial literacy and draw upon information, materials, and education programs from:

- Our executive and finance staff
- California Hospital Association staff
- Local health management school faculty
- Publications from the AHA, CHA, Health Financial Management Association (HFMA)
- Tag team with our CFO and CFO from another system
- Others?

We need to explore fresh ways to display our financial results and performance. Can our current "dashBoards" or "report cards" be enhanced so we can "make our numbers sing to us about what is happening"?

As we enhance our focus on investing for sound financial results and great quality, how can we explore incentive compensation for our Senior ExecutiveTeam that consider these performance metrics?

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 13, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/29/2017 – 8/31/2019)

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 9/29/2017 through 8/31/2019:

- **HAAK, Logan M.D. / Ophthalmology (S.D. Retina Institute)**
- **KARACHALIOS, Michael M.D. / Teleradiology (StatRad)**
- **LENNARD, William M.D. / Anesthesiology (ASMG)**
- **SAMANI, Pargol, M.D. / Cardiology (North Coast Cardiology)**
- **SHIH, Jimmy M.D. / Diagnostic Radiology (San Diego Imaging)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 13, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

ADDITIONAL PRIVILEGE REQUEST (Effective 09/29/2017, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **EBRAHIMI ADIB, Tannaz M.D.** **OB/GYN**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 09/29/2017, unless otherwise specified)
The following practitioners have voluntarily relinquished the following privileges.

- **DAUGHERTY, David M.D.** **Orthopedic Surgery**
- **MANOS, Paul DO** **Clinical Research Physician**
- **NEWMAN, Jeffrey MD** **Family Medicine**
- **POUNTNEY LEVESQUE, Marlene M.D.** **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 3 of 3
September 13, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 9/29/17, unless otherwise specified)

• CHOW, Chien-Hsiang MD	Anesthesiology
• D'SOUZA, Gehaan MD	Plastic Surgery
• DESADIER, Laure DO	Neurology
• GARNER, Darin M.D.	Emergency Medicine
• GENTILUOMO, Jesse M.D.	Emergency Medicine
• GUALBERTO, Gary MD	Neurology
• POUNTNEY LEVESQUE, Marlene MD	OB/GYN
• QUAN, Maria MD	OB/GYN
• VORA, Roshni M.D.	Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
September 13, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2017 –9/30/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 10/01/2017 through 9/30/2019, 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:

- **AMORY, David MD/Orthopedic Surgery/Active**
- **BARRON, Robert, MD/Family Medicine/Refer and Follow**
- **BURRUSS, Richard MD/Emergency Medicine/Active**
- **CALHOUN, Chanelle MD/Pediatrics/Active**
- **COLL, Jonathan MD/Teleradiology/Active-Affiliate**
- **DZINDZIO, Barry MD/Cardiology/Active**
- **GEORGY, Bassem MD/Radiology/Active**
- **GUERIN, Chris MD/Endocrinology/Active-Affiliate**
- **HENNINGER, Christopher DMD/Oral & Maxillofacial Surgery/Provisional**
- **NIELSEN, Martin MD/Pulmonary Medicine/Active**
- **ROSENBURG, Jeffrey MD/Cardiothoracic Surgery/Active**
- **SADOFF, Mark MD/Neurology/Active**
- **SCHIM, Jack MD/Neurology/Active**
- **SIDDIQUI, Farheeha MD/Oncology/Active**
- **SIGNER, Stephen MD/Psychiatry/Active-Affiliate**
- **VOIGT, Michelle MD/Emergency Medicine/Active**

Attachment B

REINSTATEMENT: (Effective Dates 10/01/2017 –9/30/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reinstatement to the medical staff office effective 10/01/2017 through 9/30/2019, 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:

- **BESSUDO, Alberto MD/Oncology**

RESIGNATIONS: (Effective date 9/30/2017 unless otherwise noted)

Automatic:

- **JOSEPH, Stephanie MD/Neurology**
- **NOWAK, Thomas MD/Neurosurgery**
- **SALIMI, Negin DO/Hospice & Palliative Medicine**

Voluntary:

- **GOODING, Isaac MD/Anesthesiology**
- **MARZAN, Yolanda MD/Anesthesiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE INITIAL CREDENTIALS REPORT
September 18, 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 09/29/2017 through 08/31/2019:

- **BRYON, Jill NP / Allied Health Professional - Orthopedics (TCMC)**
- **COCO, Kathleen CNM / Allied Health Professional - OB/GYN (NCHS)**
- **McDONOUGH, Mark PhD / Allied Health Professional - Clinical Psychologist (S.D. Neuropsychology)**
- **MEMEO, Kelly NP / Allied Health Professional - Interventional Radiology (S.D. Imaging)**
- **STAHL, Hollis PA / Allied Health Professional - Neurology (The Neurology Center)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
September 18, 2017

Attachment B

ANNUAL EVALUATIONS: The following providers have received annual evaluations and have been recommended for continued AHP membership.

- Ahumada, Alejandro G., AuD
- Allen, Danielle M., AuD
- Alston, Vickie S., CNM
- Ballantine, Katherine, CNM
- Buckley, Alicia N., OT
- Carnelian, Alissa A., AuD, CNIM
- Crespo, Christopher N., PA-C
- Deatrick, Veronica, NP
- Elamparo, Kaye L., NP
- Fazzino, Dolores L., NP, RNFA
- Forbes, Beth, RNFA
- Guthrie, Lesli A., AuD
- Hamilton Jr., James N., PAC
- Hermann, Linda, PAC
- Hermanson, Kathleen H., PA
- Inocelda, Andrew G.
- Jaramillo, Elizabeth C., AuD
- Johnson, Mark C., PA-C
- Karver-Christenson, Elyse S., CNM
- Kaur, Manpreet, PAC
- King, John F., AuD
- Kolt, Thomas L., PAC
- Laforteza, Jozelle B., NP
- Lees, Shannon E., AuD
- Leviel, Linda H., CNM
- Lister, Crystal J., CNM
- Martinez, Melinda W., PAC
- Mateo, Marie E., CNM
- McQueen, Paula S., CNM
- Mirpourian, Nabat, NP
- Olson, Lindsey D., PAC
- Perlman, Tamara L., CNM
- Pregerson, Heather A., PAC
- Schroeder, Mary L., CNM
- Silverwood, Cristie D., NP
- Son, Alicia G., PA
- Venor, Kristen A., CNM
- Wallace, Stephanie, PA-C
- Weary, Yong S., CNM

Attachment B

RESIGNATIONS:

Automatic

- **MILLER, Janet MFT/Allied Health Professional**
- **WALTERS, Janet RNFA/Allied Health Professional**

Voluntary

- **CHANDLER, Brie PAC/Allied Health Professional**
- **MCDONALD, April NP/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 18, 2017

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

ADDITIONAL PRIVILEGE REQUEST (Effective 09/29/2017, unless otherwise specified)
The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s)

- **FROST, Robert PA-C** — **Cardiothoracic Surgery**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (Effective 9/29/2017, unless otherwise specified)
The following practitioners requested to relinquish the following privileges

- **HAMMONDS, Tommy PA-C** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE CREDENTIALS REPORT – Part 3 of 3
September 18, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 9/29/17, unless otherwise specified)

- **BALLANTINE, Katherine CNM** — **OB/GYN**
- **LEVIEL, Linda CNM** — **OB/GYN**
- **SCHILLINGER, Stephan PA-C** — **Emergency Medicine**
- **SCOTT, Katie PA-C** — **Emergency Medicine**

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Interventional Radiology
Standardized Procedures

Approvals

Radiology Department (Signature): _____

Interdisciplinary Practice Committee (Date): July 14, 2017

Medical Executive Committee (Date): July 24, 2017

Professional Affairs Committee (Date): _____

Board of Directors (Date): _____

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
III. Management of Controlled Substances by the NP
IV. Supervision of the NP by Physician
V. NP Qualifications – Education and Licensing
VI. Quality Improvement

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

A. Standardized procedures for the NP are developed through collaboration among physicians, administration, and nursing, and in compliance with applicable sections of the California Code of Regulations and the California Business and Professions (B&P) Code.

B. Standardized procedures are the legal mechanism for the NP to perform functions which otherwise would be considered the practice of medicine.

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

1. The NP may function within any locations operated through Tri-City Medical Center (TCMC) designated specialty privileges as delineated on the privilege card. The NP is not permitted to order medications or place orders on a medical record unless they are physically present in TCMC locations.

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Interventional Radiology NP will:
   a. Assume responsibility for the *Interventional Radiology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Interventional Radiology Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Interventional Radiology Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for Interventional Radiology are as follows:

i. IR Intra Specialized Orders
ii. IR Intra Tunneled Procedure Medication Orders
iii. IR Intra Vascular Procedure Medication Orders
iv. IR Lung Biopsy Multiphase
v. IR Lung Biopsy Post Procedure
vi. IR Lung Biopsy Pre Procedure
vii. IR MRI with Sedation Multiphase
viii. IR Percutaneous GU/GI Drainage Multiphase
ix. IR Port/Tunneled Catheter Multiphase
x. IR Port/Tunneled Catheter Post Procedure
xi. IR Port/Tunneled Catheter Pre Procedure
xii. IR Stroke and Neurovascular Intervention Post Procedure
xiii. IR Stroke and Neurovascular Intervention Pre Procedure
xiv. IR Stroke/Neurovascular Intervention Multiphase
xv. IR TIPS Multiphase Plan
xvi. IR Thrombolysis Intervention Post Procedure
xvii. IR Tube Check Multiphase
xviii. IR Tube Check Post Procedure
xix. IR Tube Check Pre Procedure
xx. IR Vertebral Augmentation Post Procedure
xxi. IR Vertebral Augmentation Pre Procedure

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.
   1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.
      a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.
   2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Radiology.

IV. SUPERVISION BY A PHYSICIAN PURSUANT TO CA BUSINESS AND PROFESSIONS CODE

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
   1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
   1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
   2. Acute exacerbation of a patient's situation;
   3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
   4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
   5. Upon request of the patient, another clinician or Supervisor.
   6. Upon request of the NP.
   7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. 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.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
   1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
   2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
   3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
   4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.
   5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

B. The NP will maintain and upgrade clinical skills as required to meet professional standards.
   1. Documentation of participation in relevant continuing education activities.

VII. Practice Prerogatives

1. As determined by the NP – Interventional Radiology Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date
Sponsoring Physician Signature	Date

TRI-CITY MEDICAL CENTER
HUMAN RESOURCES COMMITTEE
OF THE BOARD OF DIRECTORS
September 12, 2017

Voting Members Present:	Chair Cyril Kellett, Director Rosemarie Reno, Dr. Hamid Movahhedian, Virginia Carson, Gwen Sanders Joe Quince
Non-Voting Members Present:	Steve Dietlin, CEO; Kapua Conley, COO; Sharon Schultz, CNE; Scott Livingstone, Interim CCO; Norma Braun, CHRO; Esther Beverly, VP of HR; Carlos Cruz, CCO
Others Present:	Frances Carbajal
Members Absent:	Director Leigh Anne Grass, Salvador Pilar, Dr. Martin Nielsen, 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 September 12, 2017. Director Reno moved and Ginny Carson 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.	Introduction of Carlos Cruz, newly appointed Chief Compliance Officer.	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the July 11, 2017 meeting. Director Reno moved and Ginny Carson 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. B.O.D Dahsboard	The Stakeholder Experience pillar- Employee Satisfaction rates were reviewed & discussed. RN national turnover average rate is 17%. TCHD's RN turnover rate is 12%; coming in below the national average.		Chair Kellett
b. Consideration to appoint Gwen Sanders to a second term on the Committee	Chair Kellett called for a motion to appoint Gwen Sanders to a second term on the Human Resources Committee. Ginny Carson moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
c. Consideration to appoint Virginia Carson to a second term on the Employee Fiduciary Retirement Subcommittee	Chair Kellett called for a motion to appoint Virginia Carson to a second term on the Employee Fiduciary Retirement Subcommittee. Gwen Sanders moved and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
d. Policy Discussion/Action Policy 8610-429 Alcohol & Drug Testing for Employees Policy 8610-432 Employee Transfers	The Committee reviewed Policy 8610-429. Chair Kellett called for a motion to correct misspelling on Policy 8610-429 section G.2. and send to the Board of Directors for approval. Director Reno moved and Dr. Mohavedian seconded the motion. The motion was carried unanimously. The Committee reviewed Policy 8610-432. Chair Kellett called for a motion to send Policy 8610-432 with practice changes and renewal date to the Board of Directors for approval. Ginny Carson moved and Dr. Mohavedian seconded the motion. The motion was carried unanimously.	Policy 8610-429 to be sent to Board of Directors for approval. Policy 8610-432 to be sent to Board of Directors for approval. Director Reno requested legal review of HR policies prior to submitting to committee for approval. Director Reno also requested BOD meeting minutes for labor counsel appointment approval and that this discussion reflect in this committees minutes.	Chair Kellett Chair Kellett Chair Kellett

Topic	Discussion	Action Follow-up	Person(s) Responsible
Policy 8610-483 Conflict of Interest Acceptance of Gifts	The Committee reviewed Policy 8610-483. Chair Kellett called for a motion to send Policy 8610-483 with practice changes and renewal date to the Board of Directors for approval as is. Ginny Carson moved and Dr. Mohavedian seconded the motion. The motion was carried unanimously.	Policy 8610-483 to be sent to Board of Directors for approval.	
7. 2017 Work Plan	The 2017 Work Plan was reviewed & discussed.	HRC Meeting to be held quarterly unless need to meet prior to scheduled date is deemed.	Chair Kellett
8. Committee Communications	None		Chair Kellett
9. Date of next meeting	**TBD**		Chair Kellett
10. Adjournment	Chair Kellett adjourned the meeting at 1:21 p.m.		Chair Kellett

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
Human Resources

SUBJECT: **Conflicts of Interest and Acceptance of Gifts** **POLICY NUMBER:** **8610-483**

ISSUE DATE: **08/12**
REVISION DATE(S): 08/12, 08/15

Department Approval:	**07/17**
Administrative Policies & Procedures Committee Approval:	**07/17**
Organization Compliance Committee Approval:	**08/17**
~~**Human Resources Department Approval:**~~	~~**08/15**~~
Human Resources Committee Approval:	~~**08/15**~~**09/17**
Board of Directors Approval:	**08/15**

A. **PURPOSE:**

1. This policy (1) helps policy-making managers and other employees avoid actual, potential, and perceived conflicts of interest; (2) establishes procedures designed to ensure conflicts are properly disclosed and resolved; and (3) provides guidance regarding the acceptability of gifts and gratuities.
2. This policy does not apply to acceptance of gifts from pharmaceutical vendors. Employees and their Immediate Family Members are prohibited from accepting gifts from pharmaceutical vendors. For TCHD's pharmaceutical vendor policy, see Pharmacy: ~~Services Policy Manual, Policy No.~~ 8390-10025: ~~"~~Pharmaceutical Vendors~~"~~.

B. **GENERAL POLICIES:**

1. TCHD's policy-making managers and other employees must devote their best efforts and attention to the performance of their duties and obligations at TCHD, and must avoid and promptly disclose conflicts of interest.
2. Employees shall not use TCHD information, property, or labor for personal gain, or disclose or use TCHD's confidential information for any purpose inconsistent with their official duties.
3. Employees and their Immediate Family Members are prohibited from accepting monetary gifts or gratuities, or non-monetary gifts ~~costing~~ **valued** more than $50, for their own personal benefit, from anyone doing business with, or seeking to do business with~~, the District~~ **TCHD**.
4. Employees are prohibited from soliciting gifts for their own personal benefit, of any amount or kind, from anyone doing business with, or seeking to do business with~~, the District~~ **TCHD**.
5. Employees who receive honoraria (money) for speaking on behalf of ~~the District~~**TCHD** or for participating in surveys in the course of their duties on behalf of ~~the District~~**TCHD** must give the money to Tri-City Hospital Foundation to the extent they exceed associated travel expenses.
6. At the discretion of a department manager or director, gifts such as flowers or food that can be consumed or shared by the employee's coworkers, may be accepted provided the total cost is not greater than $50 per person. This policy does not preclude employees from sending flowers or modest gifts **(at their expense)** to one another for the condolence of a death or to celebrate a special occasion.
7. Vendors, patients, visitors, physicians, and employees who wish to show their appreciation or support of TCHD and its employees by means of a substantial gift should be referred to the Tri-City Hospital Foundation.

C. **DEFINITION(S):**

1. Conflict of Interest. A conflict of interest occurs when an individual is in a position to control or

influence a business decision and has a personal, financial, or other competing interest in the outcome of the decision.

2. A competing interest arises when an individual, or his/her immediate family member, stands to gain or lose - directly or indirectly - as a result of the outcome of the matter or decision.
3. Immediate Family Member. This term means a spouse or civil union partner, natural or adoptive parent, child, or sibling: stepparent, stepchild, stepbrother or stepsister, father-in law, mother-in-law, son-in-law, daughter-in-law, brother-in- law, or sister-in-law: grandparent or grandchild: and the spouse of a grandparent or grandchild.

D. **EXAMPLES:**

1. The following is a non-exhaustive list of examples of Conflicts of Interest:
   a. An employee is a partner in an entity seeking to do business with TCHD.
   b. A manager provides confidential information to a patient to encourage a lawsuit against TCHD.
   c. An employee suggests TCHD hire a firm owned by her spouse to create hospital signage.
   d. An employee purchases property for the purpose of selling it to TCHD.
   e. A manager pressures a subordinate to hire a friend or relative.
   f. An employee commits TCHD to contract with a bank in exchange for a decreased interest rate on her car loan.

E. **PROCEDURES:**

1. All employees who believe they may have a Conflict of Interest, as described in this policy with respect to any District matter or decision must bring this concern to the immediate attention of the Compliance Officer, or the Values Line (800) 273-8452.
2. The Compliance Officer will review all Conflict of Interest disclosures and provide a written determination and instruction with respect to compliance with this policy.
3. The failure to fully, accurately, and promptly disclose actual, potential, or perceived Conflicts of Interest may result in disciplinary action, up to and including termination.

F. **SCOPE OF POLICY:**

1. This policy establishes rules for employee conduct that supplement and do not replace or excuse non-compliance with conflict of interest laws applicable to policy-making management and other employees of the District under California or Federal laws.
   a. Review of a disclosure by and receipt of instructions from the Compliance Officer do not relieve any employee from adherence to other applicable laws and policies governing local healthcare district employees, including but not limited to:
      ~~b.~~**i.** Limits on positions and ownership interests in competing hospitals (Health & Safety Code section 32110);
      ~~c.~~**ii.** Disclosure and disqualification from participating in governmental decisions as a designated person under the District's conflict of interest code under the Political Reform Act;
      ~~d.~~**iii.** Prohibitions on making contracts which may affect personal finances under Government Code section 1090;
      ~~e.~~**iv.** Use of confidential information for personal gain under Government Code section 1098;
      ~~f.~~**v.** Engaging in inconsistent, incompatible, or conflicting employment activities or enterprises, as proscribed by Government Code section 1126.

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

1. **Pharmacy: 8390-10025 Pharmaceutical Vendors**
~~g.~~**2. Employment of Relatives, 8610-406**

H. **REFERENCE(S):**

1. **CA Health & Safety Code § 32110 (2016).**
~~h.~~2. **Incompatible Activities, Cal. S. 4.7 (1125-1129), Chapter 633 (Cal. Stat, 1971).**
3. **Political Reform Act, Cal. (2017).**
4. **Prohibitions Applicable to Specific Officers, Cal. S. 4 (1090 – 1099), Chapter 134 (Cal. Stat. 1943).**

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Human Resources

ISSUE DATE: 02/87 **SUBJECT: EMPLOYEE TRANSFERS**

REVISION DATE: 05/88, 02/98, 06/00, 05/03, 02/11 **POLICY NUMBER:** 8610-432

Department Review:	**08/17**
Administrative Policies and Procedures Committee Approval:	**08/17**
Human Resources Committee Approval:	**~~09/14~~09/17**
Board of Directors Approval:	**09/14**

A. **PURPOSE:**

1. To outline the process of how **current** employees **request a** transfer to another position, ~~or~~ department, ~~or change~~ **FTE** status **or shift**.

B. **POLICY:**

1. ~~The District~~**Tri-City Healthcare District (TCHD)** strives to fill open positions with qualified candidates. All candidates must meet the qualifications of the position, and be able to perform the essential duties of the ~~vacant~~ **open** position. It is also the intent of ~~the District~~**TCHD**, however, to recognize employees for their continuous employment with ~~the District~~**TCHD**. With these principles in mind, ~~these~~ supervisors responsible for making hiring decisions should follow the procedure **outlined below. Exceptions to policy require discussion with the department head and approval by the C-Suite member responsible for the department, as well as the Chief Human Resources (CHRO) Officer.**

C. **PROCEDURE:**

1. A position **requisition** must be completed and approved for all open positions.
2. All ~~vacant~~ **open** positions should, wherever reasonable, be filled in accordance with the following procedure. ~~Vacant~~
   - **a.** **Open** positions should be posted for a minimum of three ~~working~~ **calendar** days, or per the appropriate ~~union contract~~**collective bargaining agreement**, if applicable, either within the department and/or on the established posting methods through the TCHD Human Resource**s (HR)** department and on TCHD's intranet.~~. If the position is not filled through this intra-departmental posting, then the position should be posted District-wide on the appropriate bulletin boards.~~
   - **b.** Positions may be posted and specifically designated for internal **or department** candidates only, if requested by the hiring supervisor.
   - **c.** **Positions may be filled with a qualified external candidate if there are no internal candidates received within the posting period.**
   - **d.** Internal candidates must complete an **electronic** Employee Transfer Request form and submit this form to ~~Human Resources~~**HR through the hospital applicant tracking system** prior to consideration for any ~~vacant~~ **open** positions.
   - **e.** **Generally, paper copies will not be accepted. It is the responsibility of the employee to fill out the electronic Employee Transfer Request completely, including all applicable work experience, education, licenses or certifications relevant to the position to which they are applying.**
3. ~~In addition, I~~internal candidates must have demonstrated satisfactory performance, and have worked at least six (6) months in their current position to be eligible for transfer and have had no written counseling's within the past six (6) months. ~~An exception to the six month time in~~

~~position requirement may be considered with consultation between the department head, **C-Suite** and Human Resources.~~

4. **Employees who meet the minimum requirements and are going through the interactive process shall have preference for transfer.**

~~a.~~5. **Employees who meet the minimum requirements and are on the Recall List shall have secondary preference for transfer.**

6. If multiple equally **qualified** internal applicants apply for a**n** ~~vacant~~ **open** position, the following criteria is used to choose among the various applicants:

~~**Employees on Recall List shall have first preference**~~

~~**Employee going through the interactive process**~~

~~b.~~**a.** **For positions covered by Collective Bargaining Agreements (CBA), the selection process outlined in the CBA will be followed.** ~~Benefited and other regularly scheduled employees shall have priority over Per Diem and temporary employees. However, Per Diem employees working in a specific unit/department shall have priority over benefited staff from other units/departments.~~

~~c.~~**b.** The supervisor may give preference to candidates with higher performance evaluation scores.

~~d.~~**c.** If ~~each of~~ the criteria listed above are equally met, the ~~applicant~~ **employee** with the longest ~~District~~ **TCHD** service since their last date of hire, will be given priority for selection.

~~e.~~**d.** It is the ~~candidate's~~ **employee's** responsibility to notify **his/her** ~~their~~ supervisor of a request for transfer. Before a job offer is made to an ~~internal candidate~~ **employee**, the hiring supervisor must contact the ~~candidate's~~ **employee's** current supervisor and review the ~~candidate's~~ **employee's** personnel file.

~~f.~~**e.** When the hiring supervisor makes a decision to hire an ~~internal candidate~~ **employee**, the supervisor must contact ~~Human Resources~~**HR**. The ~~Human Resources~~**HR** representative will determine the pay rate in accordance with established guidelines and make the final job offer, after consultation with the hiring supervisor.

~~g.~~**f.** The current and new supervisors will determine a mutually acceptable transfer date ~~for the internal candidate~~, which should begin with the start of a pay period whenever possible. The start date is generally fourteen (14) days from the date of job offer, and no later than thirty (30) days from the job offer date, unless otherwise agreed upon by both supervisors.

~~h.~~**g.** ~~The hiring supervisor must~~ **Human Resources~~HR will** contact all ~~internal candidates~~ **employees interviewed, but not selected**~~whose Transfer Requests they have received and any external candidates interviewed who were not selected~~, to inform them that the position has been filled.

h. ~~The hiring supervisor along with Human Resources~~**HR will generate the** ~~is responsible for initiating all~~ paperwork for transfer **and forward to the hiring supervisor to sign, obtain signature from the employee and return for data entry**.

D. RELATED DOCUMENT(S):

1. **Employee Transfer Request Form – Sample**

Employee Transfer Request Form – Sample

Tri-City Medical Center **Employee Transfer Request**

Name_____ Employee# _____ Date:_____

Position applying for: _____ **Req #** _____

Dept: _____ **Shift:** _____ **Status:** _____ (FT, PT, PD, Temp)

Current position: _____ Dept _____ Shift:

Current status: _____ (FT, PT, PD, Temporary) How long in current position:

Home phone number: _____ Work extension: _____

---

1. Have you attached a copy of your resume or completed the Employment History section? ____ Yes ____ No
   (You MUST attach a resume or complete the Employment History section)

2, Do you meet the minimum qualifications of the position?

   (See TCMC Intranet for full job description) ____ Yes ____ No

   List **(experience)** **(education)** and **(training)** that demonstrates you ability to meet the qualifications described on the posting.

   _____

   _____

3. Do you have any written counseling or suspensions in the last six (6) months? ____ Yes ____ No
4. Do you have approved time off for your current position? * ____ Yes ____ No

*(If yes, the new Manager must agree to it)

5. Have you been in your current position for at least six (6) months? (*Required*) ____ Yes ____ No
6. In addition to your current position, are you seeking an additional position? ____ Yes ____ No

*(If yes, check shifts) PD,PD ____ PT,PD____)

7. Do you have any relatives in the Department for which you are requesting a transfer? ____ Yes ____No

Note: Employees submitting transfer requests may have their personnel file reviewed by the Department Manager who has the open position.

Employee signature:_____ Date: _____

Please review Administrative Policy 432 for Internal Transfers, available on the TCMC intranet.

Updated 9/28/12

You may either attach an updated resume or complete this Employment History form.
You do **not** need both.

Employment History

(List most recent employer first)

Employer: Tri-City Medical Center Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

Employer: Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

Employer: Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

Employer: Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

Employer: Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

Employer: Department/Unit:

Job Title: Employment Dates:

Duties/Responsibilities:

DRAFT

TRI-CITY MEDICAL CENTER
EMPLOYEE FIDUCIARY RETIREMENT PLAN SUB COMMITTEE
OF THE BOARD OF DIRECTORS
September 12, 2017

Voting Members Present:	Chair Dr. Cyril Kellett, Director Rosemarie Reno, Gwen Sanders, Ginny Carson
Non-Voting Members Present:	Steve Dietlin, CEO; Kapua Conley, COO; Norma Braun, SVP; Esther Beverly, VP of HR; Carlos Cruz, CCO
Others Present:	Maureen Peer, Scott Simon, Dena Baker, Anna Lyagacheva, Marilyn Hatch, Frances Carbajal
Members Absent:	Director Leigh Anne Grass

Topic	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	Chair Kellett called the meeting to order at 11:05 a.m.		Chair Kellett
2. Approval of Agenda	Chair Kellett called for a motion to approve the September 12, 2017 meeting agenda. Director Reno moved to approve and Ginny Carson seconded the motion. The motion was carried unanimously.		Chair Kellett
3. Comments by members of the public on any item of interest to the public before Committee's consideration of the item	Chair Kellett read the paragraph regarding comments from members of the public.	Introduction of Carlos Cruz, newly appointed Chief Compliance Officer.	Chair Kellett
4. Ratification of Minutes	Chair Kellett called for a motion to approve the minutes of the May 9, 2017 meeting. Ginny Carson moved to approve and Director Reno seconded the motion. The motion was carried unanimously.		Chair Kellett
5. **Old Business**	None		

Topic	Discussion	Action Follow-up	Person(s) Responsible
6. **New Business**			
a. Lincoln Quarterly Update	Maureen Peer, Lincoln Financial Advisors Relationship Introduced Rebecca "Becky" Harris, Lincoln Sr. Account Manager. Maureen presented an executive summary which included an update from Lincoln's quarterly results & an overall 2017 year to date results. Key plan statistics, plan asset growth, contributions, earnings, participation rates, average deferral rates and account balances were also reviewed. Mrs. Peer also presented the committee with call center activity statistics. The committee discussed call types, number of call and overall statistic results.		Norma Braun
b. Prudent Quarterly Update	Dena Baker, Prudent Investment Advisor discussed ongoing efforts to reach all employees for ideal participation. Dena shared past and upcoming sessions held to maintain employees informed. MAPP & deferred comp mailers are also being sent out in efforts to grow participation rates. Scott Simon, Prudent Investment Advisor presented PIA's overall protection as Investment Advisors for TCHD.		Norma Braun
7. Comments made from the Committee	Improvements from Prudent and Lincoln vs. previous record keeper ING noted by Chair Kellett.	Chair Kellett to explore ERISA attorney review options	Chair Kellett
8. Date of next meeting	**February 13, 2018**		Chair Kellett
9. Adjournment	Chair Kellett adjourned the meeting at 11:43 a.m.		Chair Kellett

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 21, 2017

MEMBERS PRESENT: CHAC Chair Julie Nygaard, Director Jim Dagostino, Director Larry Schallock; Dr. Victor Souza, MD; Bret Schanzenbach, Carol Herrera, Dung Ngo, Gigi Gleason, Guy Roney, Linda Ledesma, Mary Lou Clift, Roma Ferriter, Scott Ashton, Ted Owen.

MEMBERS ABSENT: Barbara Perez, Danielle Pearson, Jack Nelson, Marilou de la Rosa Hruby, Mary Donovan, Mary Murphy, Rick Robinson, Rosemary Eshelman, Sandy Tucker, Xiomara Arroyo.

NON-VOTING MEMBERS PRESENT: Steve Dietlin, CEO; Kapua Conley, COO; David Bennett, Chief Marketing Officer

NON-VOTING MEMBERS ABSENT: Audrey Lopez, Fernando Sanudo

OTHERS PRESENT: Gwen Sanders

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Call To Order	The September 21, 2017 Community Healthcare Alliance Committee meeting was called to order at 12:35 pm by Director and CHAC Chair Julie Nygaard.		
Approval Of Meeting Agenda	Jim Dagostino motioned to approve the September 21, 2017 meeting agenda. The motion was seconded by Carol Herrera and unanimously approved.		
Public Comments & Announcements	No public comments or announcements were made.		

Tri-City Healthcare District
Community Healthcare Alliance Committee (CHAC)
MEETING MINUTES
September 21, 2017

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Ratification Of Minutes	Gigi Gleason motioned to approve the July 20, 2017 CHAC meeting minutes. The motion was seconded by Jim Dagostino and unanimously approved.		
Presentation: Ted Owen CEO – Carlsbad Chamber of Commerce	CEO Ted Owen presented information about the Carlsbad Chamber of Commerce as follows: • Ted thanked Tri-City Medical Center, CEO Steve Dietlin and CMO David Bennett, for their support of the Carlsbad Chamber. • Ted noted that 90% of the Chamber's members are small businesses with fewer than 10 employees. • Carlsbad's top business industry is technology. • The Carlsbad Chamber of Commerce is in its 95th year and is the 2nd largest Chamber of Commerce in the State of California. • The Chamber is currently financially sound. Ted also presented points on leadership, noting that impactful leadership is skill, combined with a positive attitude, and a helping hand to those who wish to learn and grow.		
CEO Update Steve Dietlin	CEO Steve Dietlin updated the group as follows: ▪ Steve thanked Ted Owen for his presentation and for the Chamber's support noting that Tri-City Medical Center and the community are equally important to each other. Steve again thanked Ted, and the other Chamber CEO's, for their help with TCMC's HUD financing by communicating with HUD what Tri-City Medical Center means to the District. ▪ Moving forward, Steve noted that TCMC will be focusing on completion of the service lot, entrance, parking lot and tower.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CEO Update Steve Dietlin (con't)	• Steve encouraged Committee Members to participate in the upcoming AHA walk on September 30th, noting that Tri-City Medical Center is proud to partner with the AHA to bring Heart Health education and awareness to the community. • Apx. 80% of heart issues are preventable through education and implementation of healthier lifestyles. • Steve noted that the community should be aware that TCMC offers great, cutting-edge heart care, which has the potential of decreasing wasted time that can make a difference in survival rates. • Several members who had visited the ER recently relayed that their care was top notch, noting they were proud to be cared for by such a great medical center.		
COO Update Kapua Conley	Kapua Conley noted the following: • Recently met with the Fire Chiefs of the District to review ways TCMC can better service their needs. • TCMC excels in quicker transport, ranking 2nd in the County. • TCMC ranks 1st for comprehensive surgeries and transitioning of care.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
COO Update Kapua Conley (con't)	• TCMC is planning on implementing an EMS overflow area to ease the wait times of emergency responders so they are able to get back to the needs of the community. • TCMC is working on implementing a full ED Triage room which would open up bed capacity by 60%. • The stats for the Discharge Lounge are working very well, noting that an average of 4 patients daily could save a quarter-million in costs in the period of one year. • TCMC is working with LYFT to provide transportation for discharged patients, and it is very successful with high customer satisfaction.		
CMO Update David Bennett	David Bennett updated the committee as follows: • David reiterated TCMC's excitement over the upcoming AHA Heart & Stroke walk. • It is anticipated that between 1500 and 2000 people will be in attendance. • Marketing has managed 16 events in the month of September to date. • Open Enrollment and Flu Shots dates have been scheduled.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
CMO Update David Bennett (con't)	• The Committee will arrange flu shots for the CHAC Committee Members at the October meeting. • Marketing is currently prepping for the upcoming Marathon in January.		
Committee Vacancies	Chair Julie Nygaard noted there are still two vacancies on the Committee - the Vista District Resident and the Oceanside District Resident positions.		
Public Communications	None		
Committee Communications	Roma Ferriter noted that NCHS will be holding its Health Palooza to celebrate the birth of 5,000 babies on November 4th. Carol Herrera stated that her school district was recently notified that the number one cause of death among high-school seniors has gone from auto accidents to suicide. Julie Nygaard stated that the committee may want to explore this subject further to see if help can be provided. Dung Ngo provided information regarding the U.S. economic forecast from Wells Fargo Securities.		

TOPIC	DISCUSSION	ACTION FOLLOW UP	PERSON(S) RESPONSIBLE
Next Meeting	The next meeting is scheduled for Thursday, October 19, 2017.		
Adjournment	The September 21, 2017 CHAC meeting was adjourned at 1:47pm.		

DRAFT

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
September 19, 2017

Members Present	Director Julie Nygaard, Director Laura Mitchell, Dr. Mark Yamanaka, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, Acting CFO, Kapua Conley, COO, Carlos Cruz, CCO, Susan Bond, Director, Legal Services
Others:	Thomas Moore, Jane Dunmeyer, Jeremy Raimo, David Bennett, Mark Albright, Charlene Carty, Jami Piearson, Sharon Schultz, Mary Diamond, Scott Livingstone, Sherry Miller, Norma Braun, Chris Miechowski, Priya Joshi, Maria Carapia, Candice Parras, Jody Root (Procopio), Barbara Hainsworth
Members Absent:	Director Cyril Kellett, Dr. Contardo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:33 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved to accept the agenda of September 19, 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 August 22, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Mitchell, Dr. Yamanaka seconded, that the minutes of August 22, 2017 are to be approved. Dr. Ma abstained from the vote.**	
5. Old Business			
6. New Business			

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
a. Lawson Support Services Proposal • Infor US, Inc.	Mark Albright detailed that this agreement was a multi-year support commitment for Lawson systems, including time management, payroll, accounts payable and general ledger, which includes 36 months of product support services.	**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 Infor US, Inc. for a term of 36 months, beginning June 1, 2017, and ending May 31, 2020 for a total cost for the term of $893,325.**	Mark Albright
b. Cardinal Health Supply Distribution Proposal • Cardinal Health 200, LLC	Tom Moore conveyed that this proposal was for 60 months, for contract priced supplies delivered to TCMC loading dock 5-days per week, Monday-Friday with no freight costs. It includes a team of 10 Cardinal Health supply technicians to inventory & stock all TCHD location daily and have someone on site 24/7/365. The committed minimum annual spend of $10.8M is less than TCMC's current annual spend of $12M+. It was noted that the motion for this write-up should be amended to remove the word "committed" in both locations of the last sentence, ". . . for an annual committed spend of $10,800,000 and a total committed spend for the term of $54,000,000."	**MOTION** **It was moved by Dr. Ma, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the primary medical supply distribution agreement with Cardinal Health for a term of 60 months, beginning October 1, 2017 – ending September 30, 2022 for an annual committed spend of $10,800,000 and a total committed spend for the term of $54,000,000.** **Barbara Hainsworth to amend the write-up.**	Tom Moore
c. Physician Agreement for ED On-Call Coverage – Cardiology-General • Pargol Samani, M.D.	Sherry Miller conveyed that this write-up is to add Dr. Pargol Samani as new physicians to the	**MOTION** **It was moved by Director Mitchell, Dr. Yamanaka seconded, and it was**	Sherry Miller

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	existing panel for ED On-Call coverage for General Cardiology, with no increase in expense.	**unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors add Pargol Samani, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-General for a term of 12 months, beginning October 1, 2017 – ending September 30, 2018.**	
d. Surgical Light Replacement & Video Integration Proposal, O.R. #4 • Stryker (Berchtold Lights & Stryker Video Integration) • Sun Structural Engineering (Design) • ETC Building & Design (Construction/Installation, O.R. #4) • Good-Men, Inc. (Emergency Power Relocation) • Follett (Medication Refrigerator)	Mary Diamond advised that this proposal is for the design, construction and installation of replacement surgical lights and a video system for OR #4.	**MOTION** **It was moved by Director Mitchell, Dr. Ma 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 ETC Building & Design for $99,955, and the purchase of equipment to replace the lights in operating room #4, for a total expected project cost of $510,761.27.**	Mary Diamond / Chris Miechowski
e. Retail Pharmacy Build Out Approval	Chris Miechowski conveyed that although the Board had approved the preliminary budget for the build out of a retail pharmacy inside the hospital. This proposal is to request the Committee's approval to increase the budget by $37,132 based on the bids received, and also to accept the lowest responsive bidder from the public bid process for this project. Good-Men Roofing & Construction, Inc. was the lowest responsive bidder.	**MOTION** **It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize an agreement with Good-Men Roofing and Construction, Inc. for $284,348 and a project budget increase of $37,132 to the previously board approved project budget of $336,161 in June 2017 for a total cost of $373,293 for the**	Chris Miechowski

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		construction of a Retail Pharmacy.	
f. New Seclusion Room – Inpatient Behavioral Health Unit • Good-Men Roofing & Construction, Inc.	Chris Miechowski explained that when the Crisis Stabilization Unit was opened in the Behavioral Health Unit, it eliminated the existing inpatient seclusion room. A temporary alternate was approved by CDPH, while awaiting OSHPD's approval of plans for a new seclusion room. This proposal is to request approval for Good-Men Roofing & Construction to perform the work.	**MOTION** **It was moved by Mr. Lingenfelter, Dr. Yamanaka seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize an agreement with Good-Men Roofing & Construction, Inc. for $208,828 and a total project budget of $295,482 for construction of a Seclusion Room in the Behavioral Health Unit.**	Chris Miechowski
g. Physician Consulting Agreement for Plastic Surgery Consultative & Procedural Services • Gehaan D'Souza, M.D. – Plastic Surgery	Jeremy Raimo detailed that this proposal was for Dr. Gehaan D'Souza to provide plastic surgery services to registered inpatients and observation patients on a case-by-case basis. It is anticipated that it will equate to one case per month or 12 cases per year.	**MOTION** **It was moved by Dr. Yamanaka, Dr. Ma seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Gehaan D'Souza as the Plastics Coverage Physician for a term of 12 months beginning October 1, 2017 and ending September 30, 2018, for a total cost for the term of $100,000.**	Jeremy Raimo
h. Neuroscience Health Institute – Operations Committee Agreement • Bilal Choudry, M.D.	Jeremy Raimo stated that this agreement was for Dr. Bilal Choudry to serve on the Neuroscience Health Institute's Operations Committee for one year from September 1, 2017 through August 31, 2018.	**MOTION** **It was moved by Mr. Lingenfelter, Dr. Ma seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Choudry as a Neuroscience Health Institute - Operations Committee member for a term of 12 months, beginning September 1, 2017 - ending**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.	
i. Neuroscience Health Institute – Quality Committee • Bilal Choudry, M.D.	Jeremy Raimo reported that this agreement was for Dr. Bilal Choudry to serve on the Neuroscience Health Institute's Quality Committee for one year from September 1, 2017 through August 31, 2018.	**MOTION** **It was moved by Dr. Yamanaka, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Choudry as a Neuroscience Health Institute - Quality Committee member for a term of 12 months, beginning September 1, 2017 - Ending August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.**	Jeremy Raimo
j. Cardiovascular Health Institute – Operations Committee Agreement • Paul Sarkaria, M.D.	Jeremy Raimo explained that this agreement was for Dr. Paul Sarkaria to serve on the Cardiovascular Health Institute's Operations Committee for one year from September 1, 2017 through August 31, 2018.	**MOTION** **It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize Dr. Sarkaria as a Cardiovascular Health Institute - Operations Committee member for a term of 12 months, beginning September 1, 2017 - Ending August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.**	Jeremy Raimo

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
k. Cardiovascular Health Institute – Specialty Medical Directorship Agreement • Mohammad Jamshidi-Nezhad, M.D.	Jeremy Raimo conveyed that this agreement was for Dr. Mohammad Jamshidi-Nezhad to serve as the Cardiovascular Health Institute's Specialty Medical Director for one year from September 1, 2017 through August 31, 2018.	**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 Dr. Jamshidi-Nezhad as the Specialty Medical Director for Vascular Surgery for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual cost of $30,240, and a total cost for the term of $30,240.**	Jeremy Raimo
l. First Lease Amendment – 2124 E. El Camino Real, Suite 100, Oceanside, CA 92054 • TCMC-Outpatient Physical Therapy & Occupational Medicine	Priya Joshi detailed that this was a lease amendment for the duration of 24 months for the current location of Outpatient Physical Therapy and Occupational Medicine.	**MOTION** **It was moved by Director Mitchell, Mr. Lingenfelter seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the First Amendment Lease Renewal option for Tri-City Medical Center with Norman Levitt/Levitt Family Trust for an additional two-year term, beginning September 1, 2017, ending August 31, 2019, at a total cost not to exceed $253,748.**	Kapua Conley / Priya Joshi
m. Physician Agreement for Hospitalist Services & Coverage • Coastal Hospitalist Medical Associates, Inc.	Kapua Conley reported that this is a new agreement with Coastal Hospitalist Medical Associates to bring this program to fair market value. The increase is related primarily to additional metrics assigned to the incentive pool and	**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 approve the new**	Kapua Conley

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	will be paid only if the metrics are met and TCMC is recognized for those benefits.	**Hospitalist Services and On-Site Coverage Services Agreement beginning September 1, 2017 and ending June 30, 2019 at a monthly cost of $217,917, an annual cost of $2,615,004 plus an educational allowance up to $10,000 per year, and a total cost of $4,814,174 for the term.**	
n. Financials	Ray Rivas presented the financials ending August 31, 2017 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 60,502 Operating Expense $ 62,190 EBITDA $ 1,762 EROE $ (824) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 176 Adjusted Patient Days 19,346 Surgery Cases 1,079 Deliveries 432 ED Visits 10,886 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 30,902 Operating Expense $ 31,770 EBITDA $ 864 EROE $ (429) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 182 Adjusted Patient Days 10,125 Surgery Cases 568 Deliveries 222		Ray Rivas

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	ED Visits 5,344 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 44.5 Days in Net A/R Avg. 47.7 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Adjusted Patient Days • TCMC-Emergency Department Visits		
o. Work Plan – Information Only • ED Throughput	Candice Parras gave a brief PowerPoint update on the hospital-wide Throughput Committee. She conveyed that the patients left without being seen (LWBS) goal that was set in 2016 was 3.5%, and the year-to-date for 2017 is currently 1.61%. She also discussed changes that have been implemented to improve patient flow, reduce LWBS patients and overall patient satisfaction.		Candice Parras
• Meaningful Use	Mark Albright provided a brief PowerPoint presentation overview of Meaningful Use (MU) and its objectives: • MU Definition • MU Phases • MU Stage 3 Requirements • MU Incentives = Penalty Avoidance		Mark Albright

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Crisis Stabilization *(special report)*	Sharon Schultz gave a short PowerPoint presentation update for the Crisis Stabilization Unit. The presentation covered the CSU volumes in patient hours, the average length of stay in hours, the payer mix, as well as the percentage of patients who are admitted to the BHU from the CSU.		Sharon Schultz
• Dashboard	No discussion		Ray Rivas
7. Comments by committee members	Director Nygaard took this opportunity to welcome the new Chief Compliance Officer Carlos Cruz to TCMC and to the Finance, Operations & Planning Committee.		
8. Date of next meeting	October 17, 2017		Chair
9. Community Openings (3)			
10. Adjournment	Meeting adjourned 1:30 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
LAWSON SUPPORT SERVICES PROPOSAL

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

Vendor's Name: Infor US, Inc.

Area of Service: Information Technology

Term of Agreement: 36 months, Beginning, June 1, 2017 – Ending, May 31, 2020

Maximum Totals:

	Amount:
Year 1	$289,018
Year 2	$297,688
Year 3	$306,619
Total Term Cost	**$893,325**

Description of Services/Supplies:

- Multi-year support commitment for Lawson systems to include time management, payroll, accounts payable, and general ledger.
- 36 months of product support services

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: Mark Albright, VP, IT/Information Systems / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Infor for a term of 36 months, beginning June 1, 2017, and ending May 31, 2020 for a total cost for the term of $893,325.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
CARDINAL HEALTH SUPPLY DISTRIBUTION PROPOSAL

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

Vendor's Name: Cardinal Health 200, LLC

Area of Service: Primary Medical Supply Distribution Agreement

Term of Agreement: 60 months, Beginning, October 1, 2017 – Ending, September 30, 2022

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$900,000	$10,800,000	$54,000,000

Description of Services/Supplies:

- Delivery of contract priced supplies to our back dock 5 days a week (Mon-Fri) with zero freight costs
- Team of 10 Cardinal Health supply technicians to inventory and stock all TCHD locations daily and have someone here on duty 24 hours a day, 7 days a week, 365 days a year.
- Committed annual spend minimum of $10.8M (Current annual spend is $12M+)
- Annual savings off current spend from 3 vendors invited to participate in the RFP:
  - Cardinal Health - $187,000
  - Medline - $153,000
  - Owens & Minor – Provided incomplete RFP response so total cost could not be calculated
    - The rates O&M did provide were more than we currently pay

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: Thomas Moore, Director, Materials Management / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the primary medical supply distribution agreement with Cardinal Health for a term of 60 months, beginning October 1, 2017 – ending September 30, 2022 for an annual spend of $10,800,000 and a total spend for the term of $54,000,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology-General

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

Physician's Name: Pargol Samani, M.D.

Area of Service: Emergency Department On-Call: Cardiology - General

Term of Agreement: 12 months, Beginning, October 1, 2017 – Ending, September 30, 2018

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: Cardiology, General

Rate/Day	Panel Days per Year	Panel Annual Cost
$200	365	$73,000

Position Responsibilities:

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

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

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

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

Motion:

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

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
SURGICAL LIGHT REPLACMENT AND VIDEO INTEGRATION PROPOSAL, O.R. #4

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)
ETC Building and Design (Construction/Installation OR #4)
Good-Men, Inc. (Emergency Power Relocation)
Follett (Medication Refrigerator)

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 3 Years and Misc. Accessories	$113,983.96
• Purchase of SDC 3 Base w/SDP 1000 printer kit and wireless transmitter	$56,711.00
• Construction *(publicly bid agreement with ETC Building and Design)*	$99,955.00
• Design Services, Inspection Services, Permit Fees, Contingency	$105,255.50
• Construction, E Power Relocation	$14,654.00
• Follett, LLC (Medication Refrigerator)	$4,773.86
• 8% Tax, Shipping & Handling	$37,834.17
Total Expected Cost:	**$510,761.27**

Description of Services/Supplies:

- Replacement of Surgical Lights in OR #4, along with installation of an integration system to allow for better image availability during minimally invasive surgery and storage of images; relocation of emergency power and acquisition of medication refrigerator.

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: 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 ETC Building & Design for $99,955, and the purchase of equipment to replace the lights in operating room #4, for a total expected project cost of $510,761.27.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
Retail Pharmacy Build Out Approval

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

Vendor's Name: Good-Men Roofing and Construction, Inc.

Area of Service: Retail Pharmacy

Term of Agreement: Completion of Work

Maximum Totals: $373,293

Description of Services/Supplies:

- In June 2017, the Board approved a budget of $336,161 to build a retail pharmacy inside the hospital. However, after receiving construction bids, the project cost increased by $37,132.
- Total requested budget amount of $373,293 includes Good-Men contractor cost, design fees, permit fees, inspection fees, and contingency allowance.

Retail Pharmacy Contractor Bids:	Amounts:
Good-Men	$ 284,348
Jennette	$ 338,875
ETC	$ 545,544
Pub Construction *(pulled their bid due to being incomplete)*	$ 164,812

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: Chris Miechowski, Director of Facilities / Kapua Conley, Chief Operating Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize an agreement with Good-Men Roofing and Construction, Inc. for $284,348 and a project budget increase of $37,132 to the previously board approved project budget of $336,161 in June 2017 for a total cost of $373,293 for the construction of a Retail Pharmacy.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
New Seclusion Room - Inpatient Behavioral Health Unit

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

Vendor's Name: Good-Men Roofing & Construction, Inc.

Area of Service: Behavioral Health Unit

Term of Agreement: Completion of work

Maximum Totals:

Project:	Total:
Good-Men (Construction)	$208,828
Design, Permits, Inspections, Contingency	$86,654
Total Project Cost	**$295,482**

Description of Services/Supplies:

- When we opened the Crisis Stabilization Unit in the BHU we took away the existing seclusion rooms from the In-patient BHU Unit.
- CDPH allowed us to use one of the existing rooms in the In-patient unit as a seclusion room until we processed the plans through OSHPD and built the new seclusion room.
- Good-Men Roofing & Construction, Inc. was the lowest responsive bidder. Bid results below:

Seclusion Room Bids:	Amounts:
Good-Men Roofing & Construction, Inc.	$208,828
Jennette Company, Inc.	$229,260

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: Chris Miechowski, Director of Facilities / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize an agreement with Good-Men Roofing & Construction, Inc. for $208,828 and a total project budget of $295,482 for construction of a Seclusion Room in the Behavioral Health Unit.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
PHYSICIAN CONSULTING AGREEMENT FOR PLASTIC SURGERY
CONSULTATIVE & PROCEDURAL SERVICES

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

Physician's Name: Gehaan D'Souza, M.D.

Area of Service: Hospital Inpatient Units

Term of Agreement: 12 months, Beginning, October 1, 2017 – Ending, September 30, 2018

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

12 month (Term) Cost
$100,000

Position Responsibilities:

- On a case-by-case basis, Physician to provide Plastic Surgery Services (Consultative and Procedural) for registered TCMC Hospital patients (both inpatient and observation patients)
- M.D. to provide TCMC with detailed EOB to include procedure codes
- An average of one case per month or 12 cases annually, at a per case rate of 125% of Medicare Rate for an estimated annual cost of $100K per year

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Gehaan D'Souza as the Plastics Coverage Physician for a term of 12 months beginning October 1, 2017 and ending September 30, 2018, for a total cost for the term of $100,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
Neuroscience Health Institute - Operations Committee Agreement

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

Physician's Name: Bilal Choudry, M.D.

Area of Service: Neuroscience Health Institute

Term of Agreement: 12 months, Beginning, September 1, 2017 – Ending, August 31, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	2	24	$420	$5,040	$5,040

Position Responsibilities:

Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

Document Submitted to Legal: *Outside Legal Counsel*	X	Yes		*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: Jeremy Raimo, Sr. Director Business Development / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Choudry as a Neuroscience Health Institute - Operations Committee member for a term of 12 months, beginning September 1, 2017 - Ending August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
Neuroscience Health Institute - Quality Committee Agreement

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

Physician's Name: Bilal Choudry, M.D.

Area of Service: Neuroscience Health Institute

Term of Agreement: 12 months, Beginning, September 1, 2017 – Ending, August 31, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	2	24	$420	$5,040	$5,040

Position Responsibilities:

Physician shall serve as an Quality Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

Document Submitted to Legal: *Outside Legal Counsel*	X	Yes		*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: Jeremy Raimo, Sr. Director Business Development / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Choudry as a Neuroscience Health Institute - Quality Committee member for a term of 12 months, beginning September 1, 2017 - Ending August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
Cardiovascular Health Institute - Operations Committee Agreement

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

Physician's Name: Paul D. Sarkaria, M.D.

Area of Service: Cardiovascular Health Institute

Term of Agreement: 12 months, Beginning, September 1, 2017 – Ending, August 31, 2018

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	2	24	$420	$5,040	$5,040

Position Responsibilities:

Physician shall serve as an Operations Committee Member and shall be responsible for the services as outlined in the previously approved Co-Management Agreement for the Institute.

Document Submitted to Legal: *Outside Legal Counsel*	X	Yes		*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: Jeremy Raimo, Sr. Director Business Development / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Sarkaria as a Cardiovascular Health Institute - Operations Committee member for a term of 12 months, beginning September 1, 2017 - Ending August 31, 2018. Not to exceed an average of 2 hours per month or 24 hours annually, at an hourly rate of $210 for an annual cost of $5,040, and a total cost for the term of $5,040.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
Cardiovascular Health Institute - Specialty Medical Directorship Agreement

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

Physician's Name: Mohammad Jamshidi-Nezhad, M.D., Vascular Surgery

Area of Service: Cardiovascular Health Institute

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

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	12 month (Term) Cost
$210	12	144	$2,520	$30,240	$30,240

Position Responsibilities:

Physician shall serve as Medical Director and shall be responsible for the medical direction of the listed Specialty Area and the performance of the other medical administrative services as outlined in the previously approved Co-Management Agreement for the Institute.

Document Submitted to Legal: *Outside Legal Counsel*	X	Yes		*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: Jeremy Raimo, Sr. Director Business Development / Ray Rivas, Acting Chief Financial Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize Dr. Jamshidi-Nezhad as the Specialty Medical Director for Vascular Surgery for a term of 12 months, beginning July 1, 2017 - Ending June 30, 2018. Not to exceed an average of 12 hours per month or 144 hours annually, at an hourly rate of $210 for an annual cost of $30,240, and a total cost for the term of $30,240.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
First Lease Amendment – 2124 E. El Camino Real, Ste. 100, Oceanside, CA 92054

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

Premises: 2124 E. El Camino Real, Ste. 100, Oceanside, CA 92054 (5,214 sq. ft.)
(TCMC – Outpatient Physical Therapy & Occupational Medicine)

Term of Agreement: 24 months, September 1, 2017 – Ending, August 31, 2019
First Amendment option to extend the existing lease agreement
Increasing lease payments 3% each year

Within Fair Market Value: YES (FMV was determined by Lease Comparables)

Rental Rate:

YEAR 1 - Square Foot Rate	Sq. Ft.	Monthly Rent	Monthly CAM Fees	Yearly Cost
$1.91	5,214	$9,973	$450	$125,079
YEAR 2 - Square Foot Rate	**Sq. Ft.**	**Monthly Rent**	**Monthly CAM Fees**	**Yearly Cost**
$1.97	5,214	$10,272	$450	$128,669
		Total Term Cost		**$253,748**

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

Person responsible for oversight of agreement: Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the First Amendment Lease Renewal option for Tri-City Medical Center with Norman Levitt/Levitt Family Trust for an additional two-year term, beginning September 1, 2017, ending August 31, 2019, at a total cost not to exceed $253,748.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: September 19, 2017
PHYSICIAN AGREEMENT for HOSPITALIST SERVICES & COVERAGE

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

Physicians Name: Coastal Hospitalists Medical Associates, Inc.

Area of Service: On-Site Coverage to Unassigned Patients

New Agreement Term: 22 Months – Beginning, September 1, 2017 – Ending, June 30, 2019

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

Monthly Cost	Annual Cost Not to Exceed	Education Expense (TCHD) per Year	Total NTE for 22 Month Term
$217,917	$2,615,004	$10,000	$4,814,174

The new agreement brings the Hospitalist program to Fair Market Value. The increase is primarily related to additional metrics assigned to the Incentive Pool, and will only be paid if metrics are met and TCMC has recognized those benefits. Annual cost includes Monthly Stipend, Medical Directorship, CSU/BHU Coverage, and Performance Incentives/Standards including Clinical Documentation, Supportive Care Compliance, Patient Throughput, Customer Service, Utilization Management and Quality Governance.

Position Responsibilities/Scope: Coastal Hospitalists shall provide on-site coverage for all TCMC unassigned patients, as follows:

- Provide care for patients presenting through Emergency Department who require post-ED observation care and/or inpatient admission.
- Coverage by hospitalists will ensure that there are sufficient physicians available as needed for coverage seven days per week, 24 hours per day, 365 days per year.
- Each physician who provides services shall be licensed and qualified to practice medicine in CA and be a member of TCHD's Medical Staff

Document Submitted to Legal	X	Yes		*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: Kapua Conley, Chief Operating Officer / Sharon Schultz, Chief Nurse Executive

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors approve the new Hospitalist Services and On-Site Coverage Services Agreement beginning September 1, 2017 and ending June 30, 2019 at a monthly cost of $217,917, an annual cost of $2,615,004 plus an educational allowance up to $10,000 per year, and a total cost of $4,814,174 for the Term.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
September 14, 2017

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

Non-Voting Members Present: Steve Dietlin, CEO, Kapua Conley, COO/ Exe. VP , Sharon Schultz, CNE/ Sr. VP, Carlos Cruz, Chief Compliance Officer, Scott Livingstone, Interim Chief Compliance Officer, Jody Root, General Counsel, Marcia Cavanaugh, Sr. Director for Risk Management, Jami Piearson, Director of 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: Director Jim Dagostino.

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 Dr. Contardo and seconded by Dr. Souza.	Director Mitchell
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Mitchell read the paragraph regarding comments from members of the public.		Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Ratification of minutes of August 2017.	Director Mitchell called for a motion to approve the minutes from August 10, 2017 meeting.	The minutes were ratified and was approved by the group. Dr. Souza moved and Dr. Contardo seconded the motion to approve the minutes from August 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures:** 1. Bed Utilization, Demand Greater than Capacity Policy	There was no discussion on this policy.	**ACTION:** The Patient Care policies and procedures were approved. Dr. Souza moved and Director Grass seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Blood Products Administration Procedure	There was a modification to change TCMC to TCHD on the section that says only Tri-City Medical Center employees may pick up blood products from the Lab. There was a recommendation to take out the letter H on the section pertaining to the notification of CEO when conflicts arise involving AHPs. Also, some information in the Supportive Data will be moved to procedure statement part of the policy.		
3. Chain of Command Policy	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Hands-off Communication Policy	There was no discussion on this policy.		
5. Nursing Chain of Command Policy	There was no discussion on this policy. This is a deletion.		
6. Plan for Nursing Care	There was a recommendation to use TM instead of spelling out the word trademark in using Synergy Model which is a trade marked nursing model of care, in the plan of nursing care.		
7. Rigid Laryngscope Reprocessing Procedure	There was no discussion on this policy.		
8. Skin Preparation, Surgical Procedural Policy	A brief discussion was held on the process for people who are allergic to Chlorahexidine. The hospital has other products available.		
9. Universal Protocol Procedure	The term licensed independent practitioner was replaced with AHP in this policy.		
Administrative Policies and Procedures			
1. Decision Making for Unrepresented Patients	This policy is being pulled due to a number of sections that still needs further research and clarifications. Jody Root made a recommendation to pull it.	**ACTION:** Lisa Stroud and Stephen Chavez-Matzel will work on making the proposed changes for this policy.	Patricia Guerra
2. Mandatory Reporting	There was a aclarification made on the	**ACTION:** The Administrative	

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Requirements	clarified areas of reporting under section A2. The definition for near miss/ close call was deleted in this policy.	policies and procedures were approved with the exception of the Decision Making for Unrepresented Patients policy.	
3. Policy Approval- Administrative	The yearly requirement for this policy was taken out; instead we just based it on use of regulations.	Dr. Contardo moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	
Unit Specific			
Behavioral Health Services			
1. Abuse Reporting Forms	It was identified that the forms used in BHU are different since the processes involved for this department is also distinct from the other departments of the hospital.	**ACTION:** This BHU policy was approved as moved by Director Grass and seconded by Dr. Souza.	Patricia Guerra
Education			
1. AHA: Non-TCHD Class Participants	There was a recommendation to take out the prices of the ACLS and BLS classes so the policy does not need to be changed in cases the prices increased or decreased. Prices should remain in the attached grid but not in the body of the policy.	**ACTION:** The Education policies and procedures were approved with revisions as moved by Dr. Souza and seconded by Dr. Contardo.	Patricia Guerra
2. Description of Professional Education Department	Director Mitchell posed a question regarding lunch offered by vendors who provide education to the staff. Kathy mentioned that it was allowed for as long as it is held coinciding with an inservice or education held for the benefit of the staff.		
3. Inservice Education Policy	There was no discussion on this policy.		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
4. Mission and Vision of the Educational Department Policy	There was no discussion on this policy.		
Medical Staff 1. Election Process for Member (s) at Large for MEC	Sherry Miller mentioned that the changes in this policy were brought about by the changes in the Medical staff Bylaws. The dates were also refreshed for this policy.	**ACTION:** The Medical Staff policy was approved. Dr. Ma moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health 1. Admission to Inpatient Behavioral Health Unit 2. Age Appropriate Care 3. Communications 4. Solicitation of Patients/ Referral to Self 5. Substance Abuse 6. Suicide Assessment	This policy was modified to include CSU in the process of moving patients to the inpatient behavioral health unit. There was no discussion on this policy. There was no discussion on this policy. There was no discussion on this policy. There was no discussion on this policy. There was no discussion on this policy.	**ACTION:** The policies and procedures for Outpatient Behavioral Health were all approved as moved by Dr. Souza and seconded by Director Grass.	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
Outpatient Infusion Center 1. Adverse Reaction-Medication Event	The section on calling 911 for emergency situations when having adverse reactions was added to this policy.	**ACTION:** The Outpatient Infusion Center policies and procedures were approved. Director Grass moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Central Venous Access Devices Unit	This policy was incorporated on the hospital wide policy pertaining to central venous access.		
3. Hospital Admission from the Center	There was no discussion on this policy.		
4. Outpatient Summary List Procedure	There was no discussion on this policy.		
5. Patient Discharge	There was no discussion on this policy.		
6. Physician Orders/ Request for Services	The term Allied Health Practitioner was added to this policy.		
Pharmacy 1. Transdermal Fentanyl Patch Prescribing and Use	The group made a recommendation to make some minor changes: briefly discussed the use of Methadone, the number of opiates and also, this policy needs to have the waste disposal policy as a reference.	**ACTION:** The Pharmacy policy was approved with the proposed changes. Director Grass moved and Dr. Souza seconded the motion to approve the policy moving forward for Board approval.	Patricia Guerra
Pulmonary	It was noted that EKG service is provided	**ACTION:** The policies and	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Pulmonary Scope of Services	24/7 in the hospital.	procedures for Pulmonary were all approved as moved by Dr. Souza and seconded by Director Grass.	
2. Respiratory Medication Administration	There was no discussion on this policy.		
Rehabilitation 1. Emergency Care Outpatient Services	There was no discussion on this policy.	**ACTION:** The Rehabilitation policies were approved. Director Grass moved and Dr. Johnson seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Movies, Videos	There was no discussion on this policy.		
Pre-Printed Orders 1. Cardiac Cath Lab Medication Orders	Sodium bicarbonate was taken out of this pre-printed order.	**ACTION:** The pre-printed orders were approved. Director Dagostino moved and Dr. Contardo seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. Cardiac Rehabilitation Physician Referral Orders	There is no discussion on this order.		
3. OB Scheduled C-Section Orders	Pre-operative antibiotics need to be on-call to the OR. They are usually obtained by the nurse and sent with the patient to the OR.		
6. Clinical Contracts	There were no clinical contracts that will be reviewed for this month.	**ACTION:** None.	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	Director Mitchell

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		unanimously approved to go into closed session at 1:15 PM.	
8. Return to Open Session	The Committee return to Open Session at 2:00PM.		Director Mitchell
9. Reports of the Chairperson of Any Action Taken in Closed Session	There were no actions taken.		Director Mitchell
10. Comments from Members of the Committee	No comments.		Director Mitchell
11. Adjournment	Meeting adjourned at 2:05 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
September 14, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Bed Utilization, Demand Greater than Capacity Policy – **Tracked Changes** Bed Utilization, Demand Greater than Capacity Policy – **Clean Copy**	3 Year Review, Practice Change	Forward to BOD for Approval
2. Blood Products Administration Procedure – **Tracked Changes** Blood Products Administration Procedure – **Clean Copy**	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
3. Chain of Command Policy	Practice Change	Forward to BOD for Approval with Revisions
4. Hand Off Communication Policy – **Tracked Changes** Hand Off Communication Policy – **Clean Copy**	3 Year Review, Practice Change	Forward to BOD for Approval
5. Nursing Chain of Command Policy	DELETE	Forward to BOD for Approval
6. Plan for Nursing Care – **Tracked Changes** Plan for Nursing Care – **Clean Copy**	Practice Change	Forward to BOD for Approval with Revisions
7. Rigid Laryngoscope Reprocessing Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
8. Skin Preparation, Surgical Procedural Policy	3 Year Review, Practice Change	Forward to BOD for Approval
9. Universal Protocol Procedure	Practice Change	Forward to BOD for Approval with Revisions
Administrative Policies & Procedures		
1. Decision Making for Unrepresented Patients 397	NEW	Pulled for Further Review
2. Mandatory Reporting Requirements 236 – **Tracked Changes** Mandatory Reporting Requirements 236 – **Clean Copy**	Practice Change	Forward to BOD for Approval with Revisions
3. Policy Approval-Administrative 240	Practice Change	Forward to BOD for Approval
Unit Specific		
Behavioral Health Services		
1. Abuse Reporting Forms	3 Year Review, Practice Change	Forward to BOD for Approval
Education		
1. AHA Non-TCMC Course Participants Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2. Description of Professional Education Department	3 Year Review, Practice Change	Forward to BOD for Approval
3. Inservice Education Policy	3 Year Review	Forward to BOD for Approval
4. Mission and Vision of the Education Department Policy	3 Year Review	Forward to BOD for Approval

PROFESSIONAL AFFAIRS COMMITTEE
September 14, 2017

CONTACT: Sharon Schultz, CNE

	Policies and Procedures	Reason	Recommendations
	Medical Staff		
1.	Election Process Members at Large MEC 8710-531	Practice Change	Forward to BOD for Approval
	Outpatient Behavioral Health		
1.	Admission to Inpatient Behavioral health Unit	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Age Appropriate Care	3 Year Review, Practice Change	Forward to BOD for Approval
3.	Communications	DELETE	Forward to BOD for Approval
4.	Solicitation of Patients & Referral to Self	DELETE	Forward to BOD for Approval
5.	Substance Abuse	3 Year Review, Practice Change	Forward to BOD for Approval
6.	Suicide Assessment	3 Year Review, Practice Change	Forward to BOD for Approval
	Outpatient Infusion Center		
1.	Adverse Reaction - Medication Event	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Central Venous Access Devices	DELETE	Forward to BOD for Approval
3.	Hospital Admission from the Center	3 Year Review	Forward to BOD for Approval
4.	Outpatient Summary List Procedure	DELETE	Forward to BOD for Approval
5.	Patient Discharge	3 Year Review	Forward to BOD for Approval
6.	Physician Orders Request for Services	3 Year Review	Forward to BOD for Approval
	Pharmacy		
1.	Transdermal Fentanyl Patch Prescribing and Use	Practice Change	Forward to BOD for Approval with Revisions
	Pulmonary		
1.	Pulmonary Scope of Services	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Respiratory Medication Administration	Practice Change	Forward to BOD for Approval
	Rehabilitation		
1.	Emergency Care Outpatient 1504	Practice Change	Forward to BOD for Approval
2.	Movies, Videos TR 902	DELETE	Forward to BOD for Approval
	Pre-Printed Orders		
1.	Cardiac Cath Lab Medication Orders 8711-4536	3 Year Review, Practice Change	Forward to BOD for Approval
2.	Cardiac Rehabilitation Physician Referral Orders	NEW	Forward to BOD for Approval
3.	OB Scheduled C-Section Orders 8711-1118	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 01/02

SUBJECT: Bed Utilization, Temporary Opening and Closing of Inpatient Beds/Units~~Demand Greater than Capacity~~

REVISION DATE: 03/02, 06/03, 01/04, 06/05, 03/10 08/10, 12/13

POLICY NUMBER: III.G

Department Approval:	05/17
Clinical Policies &and Procedures Committee Approval:	~~09/13~~02/~~16~~06/17
Nursing Executive Committee Approval:	~~09/13~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	~~11/13~~09/17
Board of Directors Approval:	12/13

A. **TEMPORARY OPENING OF BEDS/UNITS ~~DEMAND GREATER THAN CAPACITY:~~**

1. Admissions to the **inpatient** nursing units shall not be denied without express consent from the Director, Administrative Supervisor, Manager, or Chief Nurse Executive or designee.

2. Acute Care Services (ACS):

~~2.~~**a.** ~~Overflow of~~ **ACS** ~~acute care~~ patients **may be placed** outside of the designated nursing units ~~may occur when bed demand is greater than capacity~~ **to maximize resources.**

~~3.~~**b.** **ACS** ~~cute care a~~areas shall be staffed and equipped accordingly.

~~4.~~**3. Telemetry:**

a. During increased Telemetry census, Telemetry patients **may**~~can~~ be placed on 4 Pavilion **(4P)** and staffed with Telemetry **Registered Nurses (RN)** ~~nurses~~ at **a ratio of one RN to 4 patients (1:4).** ~~the Telemetry Staffing ratio of 1:4.~~

~~5.~~**i.** **All patients will be assigned a room on Telemetry by a Telemetry Assistant Nurse Manager (ANM) or Relief Charge Registered Nurse (RN)**

~~a. Monitor Tech and Secretary independent of Monitor Tech duties.~~

ii. Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon may be assigned a room on 4P

iii. Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W

~~b. Only Telemetry patients transferred from Telemetry unit can be sent to 4P.Telemetry level of care patients can't be directly admitted to 4P.~~

~~i. Admission criteria must be followed for acceptable patients (i.e. No chest pain on 4P).~~

4. Intensive Care Unit (ICU):

~~6.~~**a.** During increased Telemetry census for admissions only, limited program flexibility shall be initiated. Four Intensive Care Unit (ICU) beds will be designated as Telemetry admits beds for a period not to exceed 72 hours. These beds shall be staffed using licensed nurse-to-patient ratios representative of the ICU staffing ratio 1:2.

~~a.~~**i.** Nurse Managers/ANMs shall notify Regulatory Services as soon as possible, by phone or by email for submission of "temporary permission for increased patient accommodations request review and approval sheet."

5. Women and Newborn Services (WNS):

a. Overflow of Mother/Baby outside of the designated nursing units may occur when bed demand is greater than capacity. Mother/Baby shall be staffed and equipped accordingly.

6. Neonatal Intensive Care (NICU):

~~b.~~a. Per NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow).

B. **TEMPORARY CLOSING OF BEDS/UNITS:**

1. **Inpatient ~~B~~b**eds may be closed as a result of census, staffing, infection control, emergency, or maintenance problems.
   - a. Beds shall not be closed without express consent of the Unit Director or Manager or Administrative Supervisor (nights only).
   - **b. Prior to closure of a unit, the ~~Assistant Nurse Manager~~ ANM or designee is responsible for communication with the Administrative Supervisor to evaluate the potential need for beds by other departments.**
2. **Patient acuity and safety will be taken into consideration when deciding to close a unit.**
3. **The ~~Assistant Nurse Manager~~ ANM or designee must complete the Closure of Nursing Unit Checklist before the unit/beds can be considered closed and submitted to the Regulatory Compliance Department.**
4. **Intensive Care Unit:**
   - **a. Two code blue nurses are assigned from the unit that remains open.**
   - **b. The crash cart and defibrillator on the closed unit must still be checked every shift.**
   - **c. The code blue response defibrillator will remain on 1East and code blue drugs will remain in the refrigerator on 1West. It is the responsibility of the code blue RN to check the crash cart and defibrillator on the closed unit.**
   - **~~1.~~d. The charge nurse or designee must check the emergency procedure trays on 1 East and 1 West**

C. **ADMITTED PATIENTS WAITING FOR BEDS:**

1. Registration staff shall notify the Administrative Supervisor, ANM or Manager when a patient is to be admitted and a bed is not available.
2. The Administrative Supervisor, ANM or Manager shall assign the appropriate area for direct admits based on patient assessment, physician orders, and availability.

D. FORM(S):

1. **Closure of NICU Overflow Area-Checklist**
2. **Closure of Nursing Unit Checklist - Sample**
3. **~~D.~~3. Opening of Nursing Unit Checklist - Sample**

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

~~1. Intensive Care Unit Policy: Closure of Beds~~
~~2. Telemetry Policy: Opening/Closure of Telemetry Beds/Units~~

1. **~~Women's and Children's Services Manual NICU – NICU Placement: Overflow to Alternative Location (Temporary Overflow) Procedure~~NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow) Procedure**

Closure of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the appropriate beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn off Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to "shut down" printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Security
- ☐ Medical Records

Equipment Checks & Storage as follows (or per Unit guidelines):

- ☐ Crash Cart - Document on Crash Cart Checklist "Unit Closed" in the appropriate date field
- ☐ Plug in infusion pumps - store in a patient room
- ☐ Plug in Work Station on Wheels/WOWs and store in a locked room
- ☐ Place clean bedside commodes - in a patient room ~~and visitor's chairs in patient's room~~
- ☐ **Place visitor's chairs in patient's room**
- ☐ Store glucometer, doppler, pulse oximeter and other unit specific equipment in Medication Room
- ☐ Store Crash Cart and Defibrillator in Medication Room
- ☐ Nurse Locators - Place in the supply room located near the nurse's station
- ☐ Patient Charts – Store empty charts in designated area
- ☐ Patient Medications - transfer with patient or return medications to Pharmacy

Verify Patient PHI information is secured - if PHI is found, discard in Shred Bin. Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census
- ☐ SBAR and hand-off forms with patient information
- ☐ TASK list
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Open battery latch to prevent battery contact with latch or remove batteries
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit
- ☐ Verify each patient room is clean
- ☐ Turn off the lights and close doors of each patient room
- ☐ Turn off the lights in Physician Dictation Room, Supply Rooms, etc

Turn off power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer **to be turned off after 2 hours and final sweep for PHI (shared copier may be left on.**
- ☐ Forward phones to designated unit if applicable
- ☐ Close fire doors to unit and ensure they are locked
- ☐ Turn off the lights on the unit.
- ☐ Place unit keys in the ANM Office

***Fax completed form to ~~Laura Gipson,~~the Regulatory Compliance Specialist at 760-806-4645**

Opening of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the need to open beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn on Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to turn on printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Medical Records

Equipment Checks - Return equipment to operating locations and plug them into a power source:

- ☐ Crash Cart – Mark off the days the unit was closed on Crash Cart ~~Checklist as~~**Checklist as** "Unit Closed"
- ☐ Unlock supplies and equipment.
- ☐ Nurse Locators ~~– Place in the supply room located near the nurse's station~~
- ☐ Patient Charts ~~– Store in designated area~~
- ☐ ~~Patient Medications - transfer with patient or return medications to Pharmacy~~
- ☐ Check the expiration date on food left in the refrigerator as applicable

Verify Patient PHI information is secured - Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census - discard in the Shred Bin
- ☐ SBAR and hand-off forms with patient information - discard in the Shred Bin
- ☐ TASK list - discard in the Shred Bin
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Place new batteries in Telemetry boxes for assigned beds
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit **as needed**
- ☐ Verify each patient room is clean
- ☐ Turn ~~off~~ **on** the lights and ~~close~~ **open** doors of each patient room
- ☐ Turn ~~off~~ **on** the lights in Physician Dictation Room

Turn on power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ ~~Leave c~~**C**opier and printer ~~power "ON"~~**wait sufficient time for cued jobs to print and secure PHI**
- ☐ Cancel forward on phones as if applicable, confirm telephones are working
- ☐ Open fire doors to unit
- ☐ Turn on the lights on the unit.

***Fax completed form to ~~Laura Gipson,~~ the Regulatory Compliance Specialist at 760-806-4645**

Tri-City Medical Center
Oceanside, California

CLEAN COPY

PATIENT CARE SERVICES

ISSUE DATE: 01/02

SUBJECT: Bed Utilization, Temporary Opening and Closing of Inpatient Beds/Units

REVISION DATE: 03/02, 06/03, 01/04, 06/05, 03/10 08/10, 12/13

POLICY NUMBER: III.G

Department Approval:	05/17
Clinical Policies and Procedures Committee Approval:	06/17
Nursing Executive Committee Approval:	07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	09/17
Board of Directors Approval:	12/13

A. **TEMPORARY OPENING OF BEDS/UNITS:**

1. Admissions to the inpatient nursing units shall not be denied without express consent from the Director, Administrative Supervisor, Manager, or Chief Nurse Executive or designee.
2. Acute Care Services (ACS):
   a. ACS patients may be placed outside of the designated nursing units to maximize resources.
   b. ACS areas shall be staffed and equipped accordingly.
3. Telemetry:
   a. During increased Telemetry census, Telemetry patients may be placed on 4 Pavilion (4P) and staffed with Telemetry Registered Nurses (RN) at a ratio of one RN to 4 patients (1:4).
      i. All patients will be assigned a room on Telemetry by a Telemetry Assistant Nurse Manager (ANM) or Relief Charge Registered Nurse (RN)
      ii. Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon may be assigned a room on 4P
      iii. Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W
4. Intensive Care Unit (ICU):
   a. During increased Telemetry census for admissions only, limited program flexibility shall be initiated. Four Intensive Care Unit (ICU) beds will be designated as Telemetry admits beds for a period not to exceed 72 hours. These beds shall be staffed using licensed nurse-to-patient ratios representative of the ICU staffing ratio 1:2.
      i. Nurse Managers/ANMs shall notify Regulatory Services as soon as possible, by phone or by email for submission of "temporary permission for increased patient accommodations request review and approval sheet."
5. Women and Newborn Services (WNS):
   a. Overflow of Mother/Baby outside of the designated nursing units may occur when bed demand is greater than capacity. Mother/Baby shall be staffed and equipped accordingly.
6. Neonatal Intensive Care (NICU):
   a. Per NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow).

B. **TEMPORARY CLOSING OF BEDS/UNITS:**

1. Inpatient beds may be closed as a result of census, staffing, infection control, emergency, or maintenance problems.
   a. Beds shall not be closed without express consent of the Unit Director or Manager or Administrative Supervisor (nights only).
   b. Prior to closure of a unit, the ANM or designee is responsible for communication with the Administrative Supervisor to evaluate the potential need for beds by other departments.
2. Patient acuity and safety will be taken into consideration when deciding to close a unit.
3. The ANM or designee must complete the Closure of Nursing Unit Checklist before the unit/beds can be considered closed and submitted to the Regulatory Compliance Department.
4. Intensive Care Unit:
   a. Two code blue nurses are assigned from the unit that remains open.
   b. The crash cart and defibrillator on the closed unit must still be checked every shift.
   c. The code blue response defibrillator will remain on 1East and code blue drugs will remain in the refrigerator on 1West. It is the responsibility of the code blue RN to check the crash cart and defibrillator on the closed unit.
   d. The charge nurse or designee must check the emergency procedure trays on 1 East and 1 West

C. **ADMITTED PATIENTS WAITING FOR BEDS:**

1. Registration staff shall notify the Administrative Supervisor, ANM or Manager when a patient is to be admitted and a bed is not available.
2. The Administrative Supervisor, ANM or Manager shall assign the appropriate area for direct admits based on patient assessment, physician orders, and availability.

D. **FORM(S):**

1. Closure of NICU Overflow Area-Checklist
2. Closure of Nursing Unit Checklist - Sample
3. Opening of Nursing Unit Checklist - Sample

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

1. NICU Policy: NICU Placement: Overflow to Alternate Location (Temporary Overflow) Procedure

Closure of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the appropriate beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn off Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to "shut down" printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Security
- ☐ Medical Records

Equipment Checks & Storage as follows (or per Unit guidelines):

- ☐ Crash Cart - Document on Crash Cart Checklist "Unit Closed" in the appropriate date field
- ☐ Plug in infusion pumps - store in a patient room
- ☐ Plug in Work Station on Wheels/WOWs and store in a locked room
- ☐ Place clean bedside commodes - in a patient room
- ☐ Place visitor's chairs in patient's room
- ☐ Store glucometer, doppler, pulse oximeter and other unit specific equipment in Medication Room
- ☐ Store Crash Cart and Defibrillator in Medication Room
- ☐ Nurse Locators - Place in the supply room located near the nurse's station
- ☐ Patient Charts – Store empty charts in designated area
- ☐ Patient Medications - transfer with patient or return medications to Pharmacy

Verify Patient PHI information is secured - if PHI is found, discard in Shred Bin. Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census
- ☐ SBAR and hand-off forms with patient information
- ☐ TASK list
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Open battery latch to prevent battery contact with latch or remove batteries
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit
- ☐ Verify each patient room is clean
- ☐ Turn off the lights and close doors of each patient room
- ☐ Turn off the lights in Physician Dictation Room, Supply Rooms, etc

Turn off power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer to be turned off after 2 hours and final sweep for PHI (shared copier may be left on.
- ☐ Forward phones to designated unit if applicable
- ☐ Close fire doors to unit and ensure they are locked
- ☐ Turn off the lights on the unit.
- ☐ Place unit keys in the ANM Office

***Fax completed form to the Regulatory Compliance Specialist at 760-806-4645**

Opening of Nursing Unit Checklist

Location:_____Date:_____ Person(s) Completing:_____

- ☐ Confirm the need to open beds are available after all transfers and /or discharges are complete
- ☐ Complete Narcotic check on medication Pyxis (inventory)

Notify the Following: (These task may be delegated to an Unit Secretary)

- ☐ Administrative Supervisor (AS)
- ☐ Staffing Office
- ☐ Pharmacy (to turn on Pyxis access)
- ☐ Information Technology (IT) /AS (nights/weekends) (Notify to turn on printers)
- ☐ Facilities Management
- ☐ Security
- ☐ Private Branch Exchange (PBX)
- ☐ Notify the Monitor Technician (MT)
- ☐ Environmental Services
- ☐ Food & Nutrition
- ☐ Medical Records

Equipment Checks - Return equipment to operating locations and plug them into a power source:

- ☐ Crash Cart – Mark off the days the unit was closed on Crash Cart Checklist as "Unit Closed"
- ☐ Unlock supplies and equipment.
- ☐ Nurse Locators
- ☐ Patient Charts
- ☐ Check the expiration date on food left in the refrigerator as applicable

Verify Patient PHI information is secured - Check the unit for the following:

- ☐ Check all drawers and cabinets to ensure there is no unsecured PHI or logs with patient information
- ☐ Patient census - discard in the Shred Bin
- ☐ SBAR and hand-off forms with patient information - discard in the Shred Bin
- ☐ TASK list - discard in the Shred Bin
- ☐ Check Physician's dictation room (including copier) for any PHI
- ☐ Check all printers for PHI
- ☐ Check all patient rooms for PHI
- ☐ Check all supply rooms for PHI

Telemetry boxes and lead wires:

- ☐ Count Telemetry Transmitters (boxes) and lead wires. # of Telemetry boxes = _____ # of Lead wires = _____
- ☐ Place new batteries in Telemetry boxes for assigned beds
- ☐ Store clean Telemetry boxes and lead wires in wire baskets above the sink near nurses' station

Cleaning Requirements:

- ☐ Notify Environmental services to clean unit as needed
- ☐ Verify each patient room is clean
- ☐ Turn on the lights and open doors of each patient room
- ☐ Turn on the lights in Physician Dictation Room

Turn on power on the following:

- ☐ Computer monitors
- ☐ Pharmacy fax machine
- ☐ Telemetry monitoring screens
- ☐ Copier and printer wait sufficient time for cued jobs to print and secure PHI
- ☐ Cancel forward on phones as if applicable, confirm telephones are working
- ☐ Open fire doors to unit
- ☐ Turn on the lights on the unit.

***Fax completed form to the Regulatory Compliance Specialist at 760-806-4645**

Tri-City Medical Center	Distribution: Patient Care S	**TRACKED CHANGES**

PROCEDURE:	**BLOOD PRODUCTS ADMINISTRATION**
Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes packed red blood cells (PRCs), irradiated blood products, platelet concentrates, and fresh frozen plasma.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion. ~~A patient receiving blood must be accompanied by a nurse when leaving the nursing floor. Refer to "Special Considerations" sections for specific information related to each blood product listed above and for procedures for all transfusions. All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-reduced.~~
Equipment:	Blood Product 1. Blood Administration Set with a 170 micron filter 2. Normal Saline 3. IV Electronic Infusion Pump 4. Automatic BP machine 5. Pressure pump bag (if indicated)

A. **DEFINITION(S):**

1. Qualified transfusionists are:

a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration~~,~~

b. **A**~~a~~nesthesiologists

~~1.~~**c.** ~~and in surgery, p~~**P**erfusionists **in surgery**.

B. **PROCEDURE:**

1. Refer to Mosby's Nursing Skills procedure: Blood Products: Administering for complete information.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services **Policy** ~~"~~Identification, Patient~~"~~ ~~(IV.A) policy~~.
3. Verify order and complete a Transfusion Request Form
   a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.
      i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.
      ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. **Check**~~An "X" is placed in~~ the box~~,~~ which indicates the relationship of the signature for consent.
   b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.
      i. Notify physician-ordering blood if patient has not received informed consent regarding blood administration.
   c. Record ID number from the Transfusion Service identification band on Transfusion Request Form.
4. Obtain blood products from the Transfusion Service:

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Blood Utilization Review Committee	~~Pharmacy & Therapeutics Committee~~	Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/94, 7/09; 10/10;5/12	05/12;03/13; **01/15**	05/12;3/13; **2/15**	**04/17**	~~07/17~~	06/12;6/13, **08/17**	07/12;7/13, **09/17**	07/12;7/13

a. Only Tri-City ~~Medical Center~~**Healthcare District (TCHD)** employees may pick up blood products from the lab.

b. **Transfusion Services will use a dual bag system to protect patients' privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a reclosable clear plastic bag. This clear plastic bag will be placed in a white bag labeled "Handle with Care: Human Blood.** ~~To contain possible spillage of blood products not transported in a cooler and protect patients' privacy, Transfusion Services will use a dual bag system and place single and double units in a reclosable clear plastic bag which will be placed in a white bag labeled "Handle with Care Human Blood". The Transfusion Request form will be secured to the outside of the white bag for transport.~~

5. Initiate the transfusion within 30 minutes of obtaining it from the Transfusion Service

a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded.

i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.

ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.

~~a.~~**iii. Do not store blood products in any refrigerator outside of the Transfusion Service.**

~~a.~~**b.** Exception: ~~Surgery~~ **Areas designated by the laboratory** may be issued ice chests to store blood while waiting to be transfused ~~intra-operatively~~. Ice blocks are good for 6 hours, after which they must be switched for fresh ice blocks. The blood bank monitors the time limit of the ice blocks. Any remaining units of blood in the ice chest at the conclusion of the procedure must be returned to blood bank.

~~i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.~~

~~ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.~~

~~b. Do not store blood products in any refrigerator outside of the Transfusion Service.~~

6. Verify the following information from blood products, unit tag, patient chart, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist. The RN /perfusionist/anesthesiologist administering the blood products must participate in the verification process.

a. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.

i. Return blood product to Transfusion Services if number does not match.

b. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.

c. Type of blood product issued matches blood product ordered by Physician.

d. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products is compatible with patient's blood group and Rh type on the unit tags.

~~b.~~**i.** Platelet and cryoprecipitate ABO/Rh types may not **match** ~~be compatible~~ **the patient's blood ABO/Rh but are compatible to be transfused.** Call the Transfusion Service with questions concerning ABO/Rh compatibility.

~~d.~~**e.** Donor unit number on blood product label matches donor unit number on unit tag and Transfusion Record form.

~~e.~~**f.** Expiration date/time on blood product label has not elapsed.

i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight.

~~f.~~**g.** Compatibility status if blood product is red blood cell unit.

~~g.~~**h.** Document verification on Transfusion Record form and Blood Administration Powerform.

7. All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-reduced.

~~7.~~**8.** Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.
- a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.
- b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.

~~8.~~**9.** Blood may be infused using an electronic infusion device.

~~9.~~**10.** Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion.

~~10.~~**11.** Document temperature of blood warmer on Transfusion Record form.

~~11.~~**12.** **Intravenous (**IV**)** push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.

~~12.~~**13.** Change the blood administration set after 4 hours. Up to 2 units may be given with each set if the total infusion time is less than or equal to 4 hours.

14. Assess and document vital signs **(including blood pressure, heart rate, respiratory rate, and temperature)** on Blood Administration Powerform**:**
- **a.** ~~p~~**P**re-transfusion
  - **i. It is recommended that vital signs be obtained immediately prior to initiating a transfusion not to exceed 1-2 hours prior to the transfusion initiation**
- **b.** 15 minutes after blood product~~,~~
- **c.** 1 hour after blood product initiated
- **d.** ~~then e~~**E**very 1 hour until blood product infused ~~and~~
- ~~2.~~**e.** ~~i~~**I**mmediately post transfusion.
- ~~a. Vital signs include blood pressure, heart rate, respiratory rate, and temperature.~~

15. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor.

~~3.~~**16.** Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.
- a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.
- b. A form must be completed for each unit of blood product transfused.

~~13.~~**17.** Upon discharge of Outpatients, provide patient with an "Outpatient Post Transfusion Reaction" information sheet.

~~14.~~**18.** Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
- a. Check unit and patient information to verify that the unit was started on the correct patient.
- b. See Mosby's Nursing Skills Transfusions: Reaction Management
- c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.
- d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.

~~15.~~**19.** Dispose of blood product containers, and administration sets in red bags**, if no transfusion reaction**.

~~B. Special Considerations For: RH Immune Globulin~~
~~1. Ordered and obtained from the Laboratory~~
~~2. Administer Rhogam or MicRhoGAM within 72 hours of exposure to achieve optimal effect.~~

~~3. Prior to administration, verify order for fetal maternal hemorrhage screen (Kleihauer-Betke test), mother may need additional Rh Immune globulin (300 mcg standard dose)~~
~~a. Exposure to greater than 30 mL Rh-D-positive blood or 15 mL of fetal cells (i.e., abruptio placenta, placenta previa, intrauterine manipulation, and manual removal of placenta)~~
~~4. Verify the information from Rh Immune Globulin product label, unit tag, and patient information from attached armbands for the following:~~
~~a. Unit tag armband number highlighted on form must match the number on the Transfusion Service identification band attached to the patient. If number does not match, return Rh Immune Globulin to laboratory.~~
~~b. Patient's name and medical record number on hospital armband with unit tag.~~
~~c. Rh Immune Globulin lot number on product matches lot number on unit tag.~~
~~d. Expiration date on Rh Immune Globulin.~~
~~5. Verify mother's blood type and Rh prior to administration.~~
~~6. Verify baby's blood type and Rh prior to administration.~~
~~7. Complete patient identification card and give to patient after to Rhogam administration.~~

C. **Special Considerations For: Pediatric/Neonatal**

1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.
2. Verify Newborn Screening has been obtained prior to the first PRC transfusion providing Hct greater than 25 or as ordered by the physician.
3. Ensure that all blood products are CMV negative for newborns or per physician order.
4. Consult with physician regarding the use of irradiated blood and donor specific blood.
5. "Double check" all blood products prior to administration to ensure that the proper blood is administered to the infant in the neonatal intensive care (NICU).
6. Administer all blood products via **an** Alaris **pump** ~~syringe module~~ except with exchange transfusions.
7. Prime tubing with blood product and attach to T-connector or double or triple lumen connector tubing.
8. Administer blood products through largest bore catheter available (24 gauge minimum recommended).
9. Transfuse PRCs per physician order.
10. Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.
11. Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.
12. Use a controlled blood warmer when performing large volume transfusions (exchange transfusions).
13. Document, to the nearest tenth of an mL, the amount of blood product infused in the **electronic health**~~medical~~ record **(EHR)**.

D. **Special Considerations For: Intraoperative Reinfusion of Processed Blood**

1. Processed units will use a new **set**~~viaflex bag~~ each time.
2. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
3. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
4. Blood collected intra operatively is to be transfused to the donor only.
5. Contraindicated in cases of sepsis or malignancy.

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

~~8.~~**1. Patient Care Services Constavac, Reinfusion of Blood Procedure**

~~E.~~F. REFERENCES:

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services.
2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCMC Equipment Manual.
~~9. Fletcher M.A., MacDonald M.G. (Eds), Atlas of Procedures in Neonatology. J.B. Lippincott Co., 1996, Transfusion of Blood & Blood Products.~~
~~10.~~**3.** Technical Manual, American Association of Blood Banks, 17th Edition, 2011.
~~3.~~**4.** Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000.
~~4.~~**5.** AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), ~~2nd~~-**5th** Edition, W. B. Saunders, Philadelphia 1999.
~~11. C.A.T.S. Fresenius Manual: 2nd Edition, 1998~~
~~12. Cell Saver Manual.~~
~~13.~~**6.** American Blood Banks Association,Standards for Blood Banks and Transfusion Services, 27th Ediction: Bethe~~sd~~a, AABB, 2011
~~14. Besuner, P. (2007). Associtation of Women's Health, Obstetric and Neonatal Nurses (AWHONN) Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC.~~
~~15.~~**7.** Merenstein, G.B., Gardner, S.L. (**2011**~~2006~~). Handbook of Neonatal Intensive Care, **7**~~6~~th Edition. Mosby-Elsevier: Philidelphia, PA.

CLEAN COPY

Tri-City Medical Center	Distribution: Patient Care Se

PROCEDURE:	BLOOD PRODUCTS ADMINISTRATION
Purpose:	To outline the nursing care and management of adult/adolescent/pediatric/newborn patients receiving blood or blood products. This includes packed red blood cells (PRCs), irradiated blood products, platelet concentrates, and fresh frozen plasma.
Supportive Data:	Blood and blood products are unlike other intravenous medications administered due to the human/organic nature of the substance. Special precautions and timeliness are required for proper management of the patient receiving a transfusion.
Equipment:	Blood Product 1. Blood Administration Set with a 170 micron filter 2. Normal Saline 3. IV Electronic Infusion Pump 4. Automatic BP machine 5. Pressure pump bag (if indicated)

A. **DEFINITION(S):**

1. Qualified transfusionists are:
   a. Registered Nurses (RN) who have completed annual/ongoing competency in blood/blood product administration
   b. Anesthesiologists
   c. Perfusionists in surgery.

B. **PROCEDURE:**

1. Refer to Mosby's Nursing Skills procedure: Blood Products: Administering for complete information.
2. Confirm patient identity using two-identifier system. Refer to Patient Care Services Policy Identification, Patient.
3. Verify order and complete a Transfusion Request Form
   a. A nurse will verify that patient has received, read and understands, "A Patient's Guide to Blood Transfusions". The nurse will also verify that the patient has had opportunity to discuss this process with their physician.
      i. After reviewing the copy of "A Patient's Guide to Blood Transfusions" if the patient, parent, conservator or guardian refuses to permit the use of blood or blood derivatives in their care or the care of the patient, the patient will date, time and sign the refusal section of the consent.
      ii. When a patient is a minor or physically or mentally incapable of understanding and signing the consent, a parent, conservator or guardian may sign. Check the box which indicates the relationship of the signature for consent.
   b. Obtain patient's signature on consent form, if not previously signed, for all blood products from Transfusion Service.
      i. Notify physician-ordering blood if patient has not received informed consent regarding blood administration.
   c. Record ID number from the Transfusion Service identification band on Transfusion Request Form.
4. Obtain blood products from the Transfusion Service:
   a. Only Tri-City Healthcare District (TCHD) employees may pick up blood products from the lab.
   b. Transfusion Services will use a dual bag system to protect patients' privacy and contain possible spillage of blood products not transported in a cooler. Single and double units will be placed in a reclosable clear plastic bag. This clear plastic bag will be placed in a

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Blood Utilization Review Committee		Medical Executive Committee	Professional Affairs Committee	Board of Directors
5/94, 7/09; 10/10;5/12	05/12;03/13; 01/15	05/12;3/13; 2/15	04/17		06/12;6/13, 08/17	07/12;7/13, 09/17	07/12;7/13

white bag labeled "Handle with Care: Human Blood.

5. Initiate the transfusion within 30 minutes of obtaining it from the Transfusion Service
   a. It is permissible to start the transfusion even if it is delayed more than 30 minutes from issue as long as the entire unit can be infused within 4 hours of issue. After 4 hours the remainder of the unit must be discarded.
      i. Blood and blood products that are not going to be transfused should be returned to the Transfusion Service immediately, as they are temperature sensitive.
      ii. Any unused blood or blood product unit, if not transfused should be returned to the Transfusion Service.
      iii. Do not store blood products in any refrigerator outside of the Transfusion Service.
   b. Exception: Areas designated by the laboratory may be issued ice chests to store blood while waiting to be transfused. Ice blocks are good for 6 hours, after which they must be switched for fresh ice blocks. The blood bank monitors the time limit of the ice blocks. Any remaining units of blood in the ice chest at the conclusion of the procedure must be returned to blood bank.
6. Verify the following information from blood products, unit tag, patient chart, and patient information from attached armbands with another RN (in Operating Room may verify information with a Perfusionist/Anesthesiologist. The RN /perfusionist/anesthesiologist administering the blood products must participate in the verification process.
   a. Unit tag, armband number highlighted on forms must match the number on the Transfusion Service identification band attached to the patient.
      i. Return blood product to Transfusion Services if number does not match.
   b. Patient's name and medical record number on hospital armband with unit tag and Transfusion Record form.
   c. Type of blood product issued matches blood product ordered by Physician.
   d. Blood group and Rh type on blood product label matches blood group and Rh type on unit tags and for red cell products is compatible with patient's blood group and Rh type on the unit tags.
      i. Platelet and cryoprecipitate ABO/Rh types may not match the patient's blood ABO/Rh but are compatible to be transfused. Call the Transfusion Service with questions concerning ABO/Rh compatibility.
   e. Donor unit number on blood product label matches donor unit number on unit tag and Transfusion Record form.
   f. Expiration date/time on blood product label has not elapsed.
      i. If the expiration date is the current calendar day, the blood products must be infused by midnight or the remainder discarded at midnight.
   g. Compatibility status if blood product is red blood cell unit.
   h. Document verification on Transfusion Record form and Blood Administration Powerform.
7. All non-autologous PRCs and all platelet pheresis products used at this hospital are leuko-reduced.
8. Pressure Pump/Bag may be used if blood needs to be infused at a rapid rate.
   a. Use only external pressure devices equipped with a pressure gauge, and that exert uniform pressure against all parts of the blood container.
   b. Maintain 300 mmHg or less when pressure transfusing blood components as higher pressures may cause bag rupture or hemolysis through small-gauge lines.
9. Blood may be infused using an electronic infusion device.
10. Blood warmer may be used. Use only equipment specifically designed to warm blood product and maintain blood warmer temperature at specified temperature for equipment used throughout transfusion.
11. Document temperature of blood warmer on Transfusion Record form.
12. Intravenous (IV) push medication may only be given via the lowest injection port while the normal saline is infusing immediately before or after transfusing the blood product.
13. Change the blood administration set after 4 hours. Up to 2 units may be given with each set if

the total infusion time is less than or equal to 4 hours.

14. Assess and document vital signs (including blood pressure, heart rate, respiratory rate, and temperature) on Blood Administration Powerform:
    a. Pre-transfusion
        i. It is recommended that vital signs be obtained immediately prior to initiating a transfusion not to exceed 1-2 hours prior to the transfusion initiation
    b. 15 minutes after blood product
    c. 1 hour after blood product initiated
    d. Every 1 hour until blood product infused
    e. Immediately post transfusion.
15. A patient receiving blood must be accompanied by a nurse when leaving the nursing floor.
16. Complete Transfusion Record and Blood Administration Powerform including documentation of amount of blood product infused and any adverse reactions and place the chart copy of the Transfusion Record in the laboratory section of the patient's chart. Return the Blood Bank copy to the Lab.
    a. Document any adverse reactions on the Transfusion Reaction section of the Blood Administration Powerform.
    b. A form must be completed for each unit of blood product transfused.
17. Upon discharge of Outpatients, provide patient with an "Outpatient Post Transfusion Reaction" information sheet.
18. Initiate Blood Transfusion Reaction process for suspected transfusion reaction.
    a. Check unit and patient information to verify that the unit was started on the correct patient.
    b. See Mosby's Nursing Skills Transfusions: Reaction Management
    c. Complete Reaction section of the Blood Administration Powerform and the Transfusion Record form.
    d. Send blood product with attached blood administration set, the printed Blood Administration form, the Blood Bank Transfusion Record, record forms and first void urine specimen to Transfusion Service.
19. Dispose of blood product containers, and administration sets in red bags, if no transfusion reaction.

C. **Special Considerations For: Pediatric/Neonatal**

1. A nurse will verify that patient/parent/legal guardian has received, read and understands a patient guide to blood transfusion. The nurse will also verify that the patient/parent/legal guardian has had opportunity to discuss this process with their physician. Obtain consent for blood and blood products administration from parents.
2. Verify Newborn Screening has been obtained prior to the first PRC transfusion providing Hct greater than 25 or as ordered by the physician.
3. Ensure that all blood products are CMV negative for newborns or per physician order.
4. Consult with physician regarding the use of irradiated blood and donor specific blood.
5. "Double check" all blood products prior to administration to ensure that the proper blood is administered to the infant in the neonatal intensive care (NICU).
6. Administer all blood products via an Alaris pump except with exchange transfusions.
7. Prime tubing with blood product and attach to T-connector or double or triple lumen connector tubing.
8. Administer blood products through largest bore catheter available (24 gauge minimum recommended).
9. Transfuse PRCs per physician order.
10. Allow blood products to warm to room temperature (approximately 20 minutes) prior to administration to reduce thermal stress.
11. Transfuse blood over time specified by physician order, but not more than 4 hours. If transfusion orders require infusion greater than 4 hours, request smaller aliquots from the Transfusion Service.

12. Use a controlled blood warmer when performing large volume transfusions (exchange transfusions).
13. Document, to the nearest tenth of an mL, the amount of blood product infused in the electronic health record (EHR).

D. **Special Considerations For: Intraoperative Reinfusion of Processed Blood**

1. Processed units will use a new set each time.
2. Label each unit with patient's full name, Medical Record Number, date, time of start of collection, time of expiration and for "Autologous Use Only", at time of collection.
3. Reinfusion of intra operatively processed blood must begin within 6 hours of end of collection.
4. Blood collected intra operatively is to be transfused to the donor only.
5. Contraindicated in cases of sepsis or malignancy.

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

1. Patient Care Services Constavac, Reinfusion of Blood Procedure

F. **REFERENCES:**

1. Transfusion Therapy Guidelines for Nurses, National Blood Resource Education Program, Public Health Service of National Institutes of Health, U.S. Department of Health/Human Services.
2. Stryker Constavac Blood Conversion (CBC) System Operating Instructions, 98. See TCMC Equipment Manual.
3. Technical Manual, American Association of Blood Banks, 17th Edition, 2011.
4. Blood Utilization Review Committee. Chair, Gary Wilcox, M.D., 2000.
5. AWHONN Core Curriculum for Neonatal Intensive Care Nursing, Deacon, J, and O'Neil, P (Eds), 5th Edition, W. B. Saunders, Philadelphia 1999.
6. American Blood Banks Association,Standards for Blood Banks and Transfusion Services, 27th Ediction: Bethesda, AABB, 2011
7. Merenstein, G.B., Gardner, S.L. (2011). Handbook of Neonatal Intensive Care, 7th Edition. Mosby-Elsevier: Philidelphia, PA.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01 **SUBJECT:** Chain of Command

REVISION DATE: 06/03, 12/04, 10/05, 03/10, 06/13 **POLICY NUMBER:** I.J

Department Approval ~~Date(s)~~:	~~04/16~~04/17
Clinical Policies and~~&~~ Procedures Committee Approval:	~~05/16~~06/17
Nurse Executive Council Approval:	~~05/16~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/16~~08/17
Professional Affairs Committee Approval:	~~07/16~~09/17
Board of Directors Approval:	07/16

A. **PURPOSE:**

1. Chain of Command provides employees an expeditious process to resolve administrative, clinical, or other patient safety or service issues in order to provide safe patient care. All employees are encouraged to use the chain of command to present an issue of concern and pass it up the lines of authority until a resolution is reached. In situations where the safety of the patient or of employees, visitors, and others does not allow time for use of the chain of command, employees shall take the concern to the highest level he/she deems necessary.

B. **POLICY:**

1. Tri-City Healthcare District **(TCHD)** will not tolerate any acts of reprisal against those who raise issues concerning quality patient care.
2. All **TCHD employees and** health care providers (HCP) are responsible for ensuring that patients receive quality care and should implement chain of command to obtain necessary patient care interventions when the quality of care or safety of a patient is in question.
3. Examples of when to implement the chain of command may, include but are not limited to the following:
   - **a. An unresolvable issue creating a patient care/safety concern.**
   - **b. A conflict delaying or preventing the provision of patient services.**
   - **c. A disruption in ~~a~~ services(s) that cannot be resolved in an appropriate timeframe.**
   - ~~a.~~**d.** A conflict exists concerning the plan of care/physician orders for the patient.
   - ~~b.~~**e.** The plan of care is unclear and caregiver is unable to get clarification from physician.
   - ~~c.~~**f.** Qualified care professional providers are unavailable: Registered Nurses (RNs), physicians, and other essential care providers.
   - ~~d.~~**g.** Unprofessional behavior by or impairment of the healthcare providers that jeopardize patient care.
   - ~~e.~~**h.** Instances where a physician has not responded in a timely manner to a deteriorating patient condition.
   - ~~f.~~**i.** The RNs assessment of the patient varies significantly from physician's assessment.
   - ~~g.~~**j.** In clinical situations where the RN believes the physician has not responded in a manner to fully address the issues raised, that may present an immediate risk to the patient.
4. **Occurrence of an event in an area that disrupts operations and affects the public or may warrant regulatory notification:**
   - **a. Contact immediately, Monday through Friday, Area Manager/Director who will call their Area Chief and Area Chief to notify Chief Executive Officer (CEO).**

b. **Contact immediately nights, holidays, Saturday and/or Sunday, Administrative Supervisor (AS) who will call the Clinical Administrator on Call and Administrator on Call to notify the CEO.**

~~4.~~**5.** The next level of authority shall be contacted if issues are not resolved in an appropriate time frame. Progression continues through the levels of authority until the issue is resolved.

a. In some instances, one or more levels may be passed over ~~due~~**up to the area Chief or CEO due** to extremely sensitive subjects or when the higher level of authority may be the individual involved.

~~5.~~**6.** For conflicts that cannot be resolved between employees related to patient care/safety issues, the order in which the lines of authority shall be contacted are as follows:

a. The employees shall attempt to address and resolve conflict outside of the patient care area.

b. If unresolved, then the **Supervisor on Duty/Department Supervisor** ~~Assistant Nurse Manager~~ is notified.

c. If unresolved, then the ~~Clinical~~ Manager and/or ~~Administrative Supervisor~~ **AS** is notified.

d. If unresolved, then the Director is notified.

e. If unresolved, then the Senior Director is notified.

f. If unresolved, then the ~~Chief Nurse Executive (CNE)~~**Area Chief** is notified.

~~6.~~**7.** For conflicts involving physicians/Allied Health Professionals **(AHP)**, the order in which the lines of authority shall be contacted upon initiation of chain of command is as follows:

a. The HCP shall contact the ~~Assistant Nurse Manager~~**Department Supervisor/Manager** in a confidential manner to express concerns.

b. If unresolved, the ~~Clinical~~ Manager and/or ~~Administrative Supervisor~~ **AS** is notified.

c. If unresolved, the Director is notified.

d. If unresolved, the Senior Director is notified.

e. If unresolved, the ~~Senior Executive~~**Clinical Administrator on Call and** ~~, or if unavailable the~~ Administrator on Call is notified.

f. If unresolved, the ~~Medical Director~~**Department/Division Chair** of the identified department**/division** is notified.

g. If unresolved, the Chief Of Medical Staff **and CEO** ~~is~~**are** notified

~~h. If unresolved, the President/Chief Executive Officer is notified.~~

8. The ~~Administrative Supervisor~~ **AS** is available as a resource when contacting all levels of authority.

C. PROCEDURE FOR CONTACTING PHYSICIANS:

1. For instances when a call is placed to a physician and the physician has not responded in a timely manner:

a. Urgent situations:

i. If the physician has not returned the call within five (5) minutes, the HCP will contact Private Branch Exchange (PBX) for assistance in contacting the physician.

ii. PBX will make several attempts to contact the physician. If the physician has still not responded within thirty (30) minutes, PBX will notify the AS of the lack of physician response. The AS will contact the HCP for additional information regarding the situation.

iii. The AS will contact the Chief of Service.

iv. The AS will contact the Clinical On-Call as needed.

b. Non-urgent situations:

i. If the physician has not returned the call within thirty (30) minutes, the HCP will contact PBX for assistance in contacting the physician.

ii. PBX will make several attempts to contact the physician. If the physician has still not responded within one (1) hour, PBX will notify the AS of the lack of physician response. The AS will contact the HCP for additional information regarding the situation.

~~i.~~iii. **The AS will contact the Chief of Service as needed.**

~~C.~~D. DOCUMENTATION:

1. The HCP shall document the following in the medical record under clinical notes without including personal opinions:
   a. Date, time, and name of person contacted
   b. Events and observations objectively as they occur
   c. Specific facts and accurate times
2. Quality review report (QRR) shall be completed and submitted to Risk Management.

~~D.~~E. RELATED DOCUMENTS:

1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions 396

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

PATIENT CARE SERVICES

ISSUE DATE: 10/05	**SUBJECT: Hand-Off, Communication**
REVISION DATE: 02/06, 01/08, 07/08, 04/09, 08/12	**POLICY NUMBER: IV.F**

Department Approval:	**05/17**
Clinical Policies & Procedures Committee Approval:	**~~06/12~~07/17**
Nursing Executive Committee Approval:	**~~06/12~~07/17**
Medical Executive Committee Approval:	**~~07/12~~08/17**
Professional Affairs Committee Approval:	**~~08/12~~09/17**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**

1. **To improve the effectiveness or communication among caregivers.**
2. ~~1.~~ To provide a consistent, standardized, interactive approach to hand-off communications between patient caregivers ~~in accordance with 2012 National Patient Safety Goal 02.03.01~~.
3. ~~2.~~ To ensure healthcare providers communicate new, changes or updates in patient information throughout a shift **using a standardized communication process**.

B. **DEFINITION(S):**

1. **Health Care Team**: A Registered Nurse (RN), or Certified Nursing Assistant (CNA)/Advanced Care Technician (ACT) assigned to a nursing unit.
2. **Safety Hand-Off: Providing safety information including, but not limited to:**
   - a. **Patient name, diagnosis**
   - b. **Orientation (for example alert, confused, forgetful)**
   - c. **Code status, if applicable**
   - d. **Isolation status, if applicable**
   - e. **Communication barriers (hard of hearing, legally blind, non-English speaking), if applicable**
   - f. **Patient safety concerns, for example fall risk, conditions affecting ability to transfer safely**
3. **SBAR (Situation-Background-Assessment-Recommendation): a technique that provides a framework for communication between members of the health care team about a patient's condition.**
   - a. **Situation: concise statement(s) identifying the problem**
   - b. **Background: Pertinent and brief details (information) that relates to the situation**
   - c. **Assessment: your patient assessment findings, lab results, diagnostic results**
   - ~~a.~~d. **Recommendation: suggested treatments, medications, plan of care etc., that will decrease or resolve the situation**

~~2. **Shift-to-Shift Hand-Off Communication**: a process for communicating patient information between the on-coming and off-going nursing shifts as both nurses review and discuss pertinent patient information while observing the patient.~~

~~3. **Ticket to Ride**:~~

- ~~a. Form used as a method of hand-off communication during departmental transfers.~~

C. **POLICY:**

1. Healthcare providers shall use the ~~Situation, Background, Assessment, Recommendations (~~SBAR~~)~~ process when **providing** ~~conducting~~ hand-off communication.
2. Hand-off communication shall:

a. Be accurate, clear, complete, and include information about the patient's care, treatments and required services.
b. Include an opportunity for verbal communication and allow for face-to-face or telephone interaction, so questions **or concerns** about a patient's care can be **asked and** answered.
   i. Clarification and validation techniques shall be utilized to make sure there is a common understanding about expectations.
c. Include information about a patient's current condition and recent or anticipated changes.
d. **Hand-Off Rounds: ~~a process by which patients are observed by the off-going and on-coming nurses at their bedside during~~ shift-to-shift hand-off communication will include rounding by the on-coming and off-going nurses.**

3. A consistent method for patient hand-off communication shall be conducted throughout the organization during the following:
   a. Change of shift
   b. Break relief
   c. Prior to the transfer of care to another nursing unit
   ~~d. Respiratory Care Practitioner (RCP) to RCP~~
   ~~e.~~**d.** Prior to and after transfer of care to another department for a procedure/test, i.e. radiology, surgery, cardiac catherization, inpatient dialysis unit
   ~~f.~~**e.** Prior to transferring**/discharging** a patient to another facility
   ~~g. Prior to discharge to a skilled nursing facility~~
   ~~h. Any c~~**C**~~hange in level of care requirements **identified by non-TCMC employees assisting with the safety of patients on the Progressive Care Unit** communicated to California Department of Corrections and Rehabilitation (CDCR) authority for forensic patients~~

4. Shift Team Update: A brief verbal communication between licensed staff (RN) and ACTs to provide pertinent information regarding individual patient assignments.
   a. Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication.
   b. Shift Team Updates shall continue throughout the shift as needed, to improve communication between all members of the health care team.

~~b.~~**5. If patient is transported and unaccompanied by a licensed nurse, nurse shall provide a safety hand-off to the transporter.**

D. **HAND-OFF COMMUNICATION REFERENCES:**

1. The following references may be used **to provide**~~for~~ hand-off communications:
   a. History and Physical
   b. **Electronic Health Record (EHR) patient care applications** ~~Appropriate Cerner PowerChart Organizer tabs~~ i.e. ~~O~~**o**rders, ~~L~~**l**abs, ~~V~~**v**ital ~~S~~**s**igns
   ~~b.~~**c.** **Electronic kardex**
   ~~c.~~**d.** Electronic Medication Administration Record (eMAR)
   ~~d.~~**e.** Medication Administration Record (MAR) summary
   ~~e.~~**f.** Physician's Orders
   ~~f.~~**g.** Physician's Progress Notes
   ~~g.~~**h.** Chart Summary Screen
   ~~h.~~**i.** SBAR Shift-to Shift Hand-off Communication form

E. **NURSING SHIFT-TO-SHIFT HAND-OFF / TRANSFER OF CARE TO ANOTHER NURSI~~S~~NG UNIT:**

~~2.~~**1.** May include but is not limited to:
   a. Patient Information (name, age, physician, diagnosis)
   b. Code status
   c. Isolation status
   d. Allergies

e. Abnormal assessment findings **(labs, vital signs, physical assessment)**
f. Pertinent Physician Orders
g. Any patient safety concerns (i.e. falls, medications **that may contribute to falls, seizure precautions, and/or** equipment)
h. Case management/social service concerns related to the plan of care
i. Medications/key interventions requiring follow-up by ~~given by~~the receiving unit or oncoming shift
i. Pain level and time pain medication was last given, if applicable
~~**Recommendation to review computer**~~

~~3.~~**2.** Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:
a. All pertinent **pre/**post-surgical**/procedural** information
b. Whereabouts of family and belongings

~~E.~~**F. BREAK RELIEF:**
1. **Patient information** (name, age, physician, diagnosis)
2. Current condition and status (level of consciousness, vital signs)
3. Code status
4. Isolation status
5. Patient safety
6. Medications or tasks due or in progress ~~i.e. blood transfusion~~
7. ~~Other specific concerns/information related to the break time i.e. c~~**C**alls placed to physicians

~~F. TRANSFER OF CARE TO ANOTHER NURSING UNIT~~
~~1. Transfer hand-off shall include but is not limited to nursing shift-to-shift hand-off information.~~
~~2. Documentation~~
~~a. Sending nurse shall document on Off Unit/Transfer Assessment Powerform and complete the Ticket to Ride~~
~~b. Receiving nurse shall document receipt of patient on the Off Unit/Transfer Assessment Powerform and on the Ticket to Ride.~~
~~3. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide hand-off to the transporter.~~

~~G. TRANSFER OF CARE TO TRANSPORTERS:~~
~~1. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide verbal hand-off to the transporter and review the Ticket to Ride.~~

~~H.~~**G. RESPIRATORY CARE PRACTITIONER (RCP) TO RCP:**
1. A verbal report, face-to-face, or telephone hand-off shall be conducted.
a. When verbal report, face-to-face, or telephone hand-off is not possible, a written report shall be completed by the off-going RCP.
i. The off-going RCP written report shall include the hand-off information listed below.
2. Hand-off ~~shall~~ **may** include**, but not limited to,** the following information:
a. Patient identifiers
b. Code status
c. Isolation status
d. Pulmonary Diagnoses
e. Time last treatment was conducted
f. Breath sounds
g. Vital signs including last pulse oximeter reading
h. Cough and/or sputum
i. Mental status including vision or hearing impairments
j. Abnormal or unusual respiratory conditions (i.e. hemoptysis)
k. Pertinent lab results

l. Ventilator settings as applicable
m. Patient safety concerns, for example fall risk and conditions affecting ability to transfer safely~~Fall risk~~
~~m.~~**n. Medications/key interventions requiring follow-up by given by the oncoming shift**

~~I. SURGICAL SERVICES PATIENT TRANSFERS:~~
~~1. Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:~~
~~a. All pertinent post-surgical information~~
~~b. Whereabouts of family and belongings~~

~~J. FROM PATIENT CARE AREAS TO SURGERY:~~
~~1. The Pre-Operative or Post-Anesthesia Care Unit (PACU) RN shall call the floor/ED and hand-off from the primary care nurse or designee responsible for the patient or review the Pre-Operative Procedure Powerform on Cerner.~~
~~2. Hand-off communication shall include the following:~~
~~a. Pertinent shift-to-shift information~~
~~b. Verification of information on pre-op~~

~~K. PROCEDURE TRANSFERS:~~ **(see new procedure)**
~~1. Sending Department:~~
~~a. Healthcare provider to complete and update the Cerner Off Unit/Transfer Assessment Powerform and Ticket to Ride~~
~~b. Ensure patient's hardcopy chart accompanies patient.~~
~~c. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide hand-off to the transporter.~~
~~d. Telemetry and Acute Care Services (ACS) Monitored units nursing staff shall notify the Monitor Tech per the Transporter Communication Procedure~~
~~2. Procedural/Diagnostic Department:~~
~~a. Shall receive a safety hand-off from the transporter.~~
~~b. Shall review the Off Unit/Transfer Assessment Powerform.~~
~~c. Contact the healthcare provider if there are any questions.~~
~~d. Prior to transferring the patient update Cerner Off Unit/Transfer Assessment Powerform.~~
~~e. If patient is transferred unaccompanied by a licensed nurse, nurse shall provide verbal hand-off to the transporter and review the Ticket to Ride.~~
~~3. Return to Sending Department (following procedure):~~
~~a. Shall receive a safety hand-off from the transporter~~
~~b. Healthcare provider shall review the Cerner Off Unit/Transfer Assessment Powerform: Procedure Area Report~~
~~c. Assess the patient~~
~~d. Document receipt of patient on the Off Unit/Transfer Assessment Powerform: Return/Received screen and complete Ticket to Ride~~
~~e. Document any changes in the patient's status in the medical record~~

H. RELATED DOCUMENT(S):

~~L.~~1. ~~TRANSFER TO ANOTHER FACILITY: See~~ **Patient Care Services Policy:** Transfer of Patients ~~Policy~~
~~M.~~2. ~~DISCHARGE: See~~**Patient Care Services Policy:** Discharge of Patients ~~Policy~~

~~N.~~I. REFERENCES:

1. Caruso, E. (2007~~, February~~). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MEDSURG Nursing, 16*(1), 17-22.
2. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside Nurse-to-NurseHandoff Promotes Patient Safety. *MEDSURG Nursing*, *21*(3), 140-145.

3. Hand-off communications. (2007). AORN Journal, 86S146-9:10.1016/J.Aorn.2007.11.012 CINAHL Plus
4. Risenber, L. A., Leisch, J. & Cunningham, J. (2010~~, April~~). Nursing handoffs: A systematic review of the literature. *AJN, American Journal of Nursing*, 110(4), 24-34
5. Patient safety: "a ticket to ride" protects patients off the unit. *Nursing 2012, 39* (5), 57-58. Retrieved from http://www.nursingcenter.com/Inc?journal?Article_ID=858666
7. Patients at this hospital have a "ticket to ride." Healthcare Benchmarks Qual Improv. 2006; 13(9): 102-104

Tri-City Medical Center
Oceanside, California

CLEAN COPY

PATIENT CARE SERVICES

ISSUE DATE: 10/05	**SUBJECT: Hand-Off, Communication**
REVISION DATE: 02/06, 01/08, 07/08, 04/09, 08/12	**POLICY NUMBER: IV.F**

Department Approval:	**05/17**
Clinical Policies & Procedures Committee Approval:	**07/17**
Nursing Executive Committee Approval:	**07/17**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**08/12**

A. **PURPOSE:**
1. To improve the effectiveness or communication among caregivers.
2. To provide a consistent, standardized, interactive approach to hand-off communications between patient caregivers.
3. To ensure healthcare providers communicate new, changes or updates in patient information throughout a shift using a standardized communication process.

B. **DEFINITION(S):**
1. Health Care Team: A Registered Nurse (RN), or Certified Nursing Assistant (CNA)/Advanced Care Technician (ACT) assigned to a nursing unit.
2. Safety Hand-Off: Providing safety information including, but not limited to:
   a. Patient name, diagnosis
   b. Orientation (for example alert, confused, forgetful)
   c. Code status, if applicable
   d. Isolation status, if applicable
   e. Communication barriers (hard of hearing, legally blind, non-English speaking), if applicable
   f. Patient safety concerns, for example fall risk, conditions affecting ability to transfer safely
3. SBAR (Situation-Background-Assessment-Recommendation): a technique that provides a framework for communication between members of the health care team about a patient's condition.
   a. Situation: concise statement(s) identifying the problem
   b. Background: Pertinent and brief details (information) that relates to the situation
   c. Assessment: your patient assessment findings, lab results, diagnostic results
   d. Recommendation: suggested treatments, medications, plan of care etc., that will decrease or resolve the situation

C. **POLICY:**
1. Healthcare providers shall use the SBAR process when providing hand-off communication.
2. Hand-off communication shall:
   a. Be accurate, clear, complete, and include information about the patient's care, treatments and required services.
   b. Include an opportunity for verbal communication and allow for face-to-face or telephone interaction, so questions or concerns about a patient's care can be asked and answered.
      i. Clarification and validation techniques shall be utilized to make sure there is a common understanding about expectations.

c. Include information about a patient's current condition and recent or anticipated changes.
d. Hand-Off Rounds: ~~a process by which patients are observed by the off-going and on-coming nurses at their bedside during~~ shift-to-shift hand-off communication will include rounding by the on-coming and off-going nurses.

3. A consistent method for patient hand-off communication shall be conducted throughout the organization during the following:
   a. Change of shift
   b. Break relief
   c. Prior to the transfer of care to another nursing unit
   d. Prior to and after transfer of care to another department for a procedure/test, i.e. radiology, surgery, cardiac catherization, inpatient dialysis unit
   e. Prior to transferring/discharging a patient to another facility
4. Shift Team Update: A brief verbal communication between licensed staff (RN) and ACTs to provide pertinent information regarding individual patient assignments.
   a. Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication.
   b. Shift Team Updates shall continue throughout the shift as needed, to improve communication between all members of the health care team.
5. If patient is transported and unaccompanied by a licensed nurse, nurse shall provide a safety hand-off to the transporter.

D. HAND-OFF COMMUNICATION REFERENCES:

1. The following references may be used to provide hand-off communications:
   a. History and Physical
   b. Electronic Health Record (EHR) patient care applications i.e. orders, labs, vital signs
   c. Electronic kardex
   d. Electronic Medication Administration Record (eMAR)
   e. Medication Administration Record (MAR) summary
   f. Physician's Orders
   g. Physician's Progress Notes
   h. Chart Summary Screen
   i. SBAR Shift-to Shift Hand-off Communication form

E. NURSING SHIFT-TO-SHIFT HAND-OFF / TRANSFER OF CARE TO ANOTHER NURSING UNIT:

1. May include but is not limited to:
   a. Patient Information (name, age, physician, diagnosis)
   b. Code status
   c. Isolation status
   d. Allergies
   e. Abnormal assessment findings (labs, vital signs, physical assessment)
   f. Pertinent Physician Orders
   g. Any patient safety concerns (i.e. falls, medications that may contribute to falls, seizure precautions, and/or equipment)
   h. Case management/social service concerns related to the plan of care
   i. Medications/key interventions requiring follow-up by the receiving unit or oncoming shift
      i. Pain level and time pain medication was last given, if applicable
2. Surgical Services hand-off shall include nursing shift-to-shift hand-off information as well as:
   a. All pertinent pre/post-surgical/procedural information
   b. Whereabouts of family and belongings

F. BREAK RELIEF:

1. Patient information (name, age, physician, diagnosis)
2. Current condition and status (level of consciousness, vital signs)

3. Code status
4. Isolation status
5. Patient safety
6. Medications or tasks due or in progress
7. Calls placed to physicians

G. **RESPIRATORY CARE PRACTITIONER (RCP) TO RCP:**

1. A verbal report, face-to-face, or telephone hand-off shall be conducted.
   a. When verbal report, face-to-face, or telephone hand-off is not possible, a written report shall be completed by the off-going RCP.
      i. The off-going RCP written report shall include the hand-off information listed below.
2. Hand-off may include, but not limited to, the following information:
   a. Patient identifiers
   b. Code status
   c. Isolation status
   d. Pulmonary Diagnoses
   e. Time last treatment was conducted
   f. Breath sounds
   g. Vital signs including last pulse oximeter reading
   h. Cough and/or sputum
   i. Mental status including vision or hearing impairments
   j. Abnormal or unusual respiratory conditions (i.e. hemoptysis)
   k. Pertinent lab results
   l. Ventilator settings as applicable
   m. Patient safety concerns, for example fall risk and conditions affecting ability to transfer safely
   n. Medications/key interventions requiring follow-up by given by the oncoming shift

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

1. Patient Care Services Policy: Transfer of Patients
2. Patient Care Services Policy: Discharge of Patients

I. **REFERENCES:**

1. Caruso, E. (2007). The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MEDSURG Nursing, 16*(1), 17-22.
2. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside Nurse-to-NurseHandoff Promotes Patient Safety. *MEDSURG Nursing*, *21*(3), 140-145.
3. Hand-off communications. (2007). AORN Journal, 86S146-9:10.1016/J.Aorn.2007.11.012 CINAHL Plus
4. Risenber, L. A., Leisch, J. & Cunningham, J. (2010). Nursing handoffs: A systematic review of the literature. *AJN, American Journal of Nursing*, 110(4), 24-34
5. Patient safety: "a ticket to ride" protects patients off the unit. *Nursing 2012, 39* (5), 57-58. Retrieved from http://www.nursingcenter.com/Inc?journal?Article_ID=858666
7. Patients at this hospital have a "ticket to ride." Healthcare Benchmarks Qual Improv. 2006; 13(9): 102-104

Tri-City Medical Center
Oceanside, California

DELETE – Incorporated into Patient Care Services: Chain of Command

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 3/02

SUBJECT: Nursing Chain of Command

REVISION DATE: 6/03, 5/05, 4/09, 1/11

POLICY NUMBER: I.J

Department Approval:	~~12/16~~04/17
Clinical Policies & Procedures Committee Approval:	~~11/11~~02/~~17~~06/17
Nursing Executive Committee Approval:	~~11/11~~02/~~17~~07/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/12~~03/~~17~~08/17
Professional Affairs Committee Approval:	~~02/12~~09/17
Board of Directors Approval:	02/12

~~A. **POLICY:**~~

~~1. The Chief Nurse Executive (CNE) is ultimately responsible for oversight of operations of all nursing units.~~

~~2. The Senior Director of Preoperative and Women's and Childrens' Services provides coverage of effectiveness of daily operations of all nursing units in the absence of the CNE~~

~~3. The Clinical Managers and Directors are responsible to the CNE s for the operation of assigned nursing units or services.~~

~~4. The Assistant Nurse Managers (ANM) is responsible to the Manager/Director, CNE and/or Administrative Supervisor on duty for managing staff and directing patient care on their assigned shift.~~

~~5. The Registered Nurse (RN) is responsible to the ANM/Relief Charge Nurse for providing total patient care utilizing the nursing process.~~

~~6. The designated RN acts as a "patient manager" to provide outcome oriented patient management within a fiscally responsible time frame. Support staff (i.e. Nursing Assistants, Unit Secretaries and Technicians) report to the RN.~~

~~7. The Administrative Supervisors on duty are responsible to the Clinical Managers/Director for the management of patient care activities and hospital operations on their assigned shift. They have authority to act in the absence of the CNE and Clinical Managers/Director. They report to the Director of Education, Clinical Informatics, and Staffing.~~

~~8. The Director of Education, Clinical Informatics, and Staffing is responsible for maintaining oversight of the Staffing Office, Resource Network, and Administrative Supervisors.~~

~~9. Clinical Educators are responsible to Directors and the Director of Education, Clinical Informatics, and Staffing for staff education in assigned areas of responsibilities.~~

Tri-City Medical Center
Oceanside, California

TRACKED CHANGES

Plan for Nursing Care

I. **PURPOSE**

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services **(PCS)** are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements;
   2. The Hospital's recruitment, retention, and staff development capabilities;
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities;
   4. Evaluation of innovations and improvements in patient care;
   5. Affiliations, managed care contracts and reimbursement changes;
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues;
   7. The Hospital's Strategic and Facilities Plan and annual budget;~~.~~
   8. Regulatory or accreditation changes;
   ~~8.~~9. Collective Bargaining Agreement (CBA) revisions.

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. **DEFINITION OF NURSING**

~~1. The practice of the profession of nursing is defined as diagnosing and treating human response to actual or potential health problems within the following domains:~~
~~a. Protection,~~
~~b. Promotion and optimization of health and abilities,~~
~~c. Prevention of illness and injury,~~
~~d. Alleviation of suffering through the diagnosis and treatment of human response~~
~~e. Advocacy in the care of individuals,families, communities, and populations.~~

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and ~~and~~ injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations. American Nurses Association, Scope of Practice, 2015 3rd Ed.

III. **NURSING VISION AND DISTRICT VALUES**

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City **Healthcare District (TCHD)**~~Medical Center~~.

~~A.~~B. The needs of our patients come first.

~~a. We are Tri-City Nursing, Patients are our # 1 Priority~~
~~b. We are dedicated to providing Quality patient care and service for our patients~~

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/16, **06/17**	09/16, **07/17**	**09/16, 07/17**	n/a	**10/16, 08/17**	**09/17**	

~~c. We are Caring and demonstrate this to patients, physicians and each other with concern dignity, kindness and respect.~~
~~d. We strive for the Safety and well being of our patients and each other.~~
~~e. We have a strong sense of Integrity, being ethical and transparent in all we do.~~
~~f. We promote Innovation in Nursing Practice, believing that evidence and research influence outcomes.~~
~~g. We commit to community Stewardship to achieve community health and wellness~~

IV. GUIDING PRINCIPLES

A. We never lose sight of our patients' and families' needs and expectations.
B. We strive to make the most efficient use of our resources.
C. We are alert for opportunities to improve.
D. We encourage patients and families to participate in their care and decisions affecting their care.
E. We focus on team relationships and healthy interpersonal skills.
F. We enter into partnerships with patients, families, and other health care professionals eagerly.
G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing, including but not limited to, the direct provision of care, establishing effective administrative systems, managing and delivering educational experiences, enhancing lifelong learning and supporting nursing research.

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at ~~Tri-City Medical Center~~**TCHD** believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
   1. Caring - is the essence of nursing. A caring approach includes: knowledge, adaptable approaches based on the care-recipient's unique needs, patience, honesty, trust, humility, hope and courage.
   2. Diversity - is a core element for caring and leadership. It requires that the individual affirm his or her own unique self while learning to respect and address the needs of others who may have different values.
   3. Accountability - is the hallmark of professional practice. It requires responsibility to set personal standards for accomplishing expected goals, objectives and outcomes; for relationships and working together (collegiality); for supporting colleagues/peers; and for adherence to organizational policy and procedure.
   4. Integrity - is the foundation for clinical practice, leadership, and learning. It encompasses a commitment to people (staff, colleagues, families, community, and adherence to the professional nursing code of ethics and professional nursing standards of practice.
   5. Advocacy - is an inherent element of nursing ethics and nursing practice. As an advocate, the nurse is responsible for safeguarding, promoting, and supporting the patient's values and decisions.
   6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing, transcultural nursing care and leadership. Experienced nurses serve as mentors to others in assisting them to achieve a higher level of evidence-based practice.

VI. SCOPE OF PATIENT CARE

A. Patient care at ~~Tri-City Medical Center~~**TCHD** encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. This care is provided collaboratively by health care providers with specialized knowledge, judgment and skill. Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.

1. All PCS departments have a plan that describes their scope of service.

VII. PRACTICE STANDARDS

A. American Nurses Association Code of Ethics for Nurses **2015 2nd Ed.**– Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at ~~Tri-City Medical Center~~**TCHD** to use in ethical analysis and decision-making. The nine provisions of the Code of Ethics describe the most fundamental values and commitments of the nurse, boundaries of duty and loyalty and duties beyond individual patient encounters. **These interpretive statements are** ~~It is~~ not negotiable in any setting~~.~~**:**

1. Respect for Others
2. Commitment to the Patient
3. Advocacy for the Patient
4. Accountability and Responsibility for Practice
5. Duty to Self and Duty to Others
6. Contribution to Healthcare Environments
7. Advancement of the Nursing profession
8. Promotion of Community and World Health
9. Promotion of the Nursing Profession

B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.

~~A.~~**C.** California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. ~~Tri-City~~**TCHD** nurses are responsible to be informed of these laws.

~~A. American Association of Critical-Care Nurses Healthy Work Environment- Healthy work environments foster excellence in patient care. Tri-City Medical Center Nurses are committed to establishing and sustaining work and care environments that are healthy, healing, humane and respectful of the rights, responsibilities, needs and contributions of all people – including patients, their families and nurses.~~

VIII. PATIENT CARE MODEL: SYNERGY™~~(uses trademark)~~

A. ~~Tri-City Medical Center~~**TCHD** Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.

B. The Synergy model delineates three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system.

C. Nurse Competencies:
1. Clinical judgment, including decision making, critical thinking and basic nursing skills.
2. Caring practices, responding to the unique needs of patients and families.
3. Advocacy to help identify and resolve concerns as they arise.
4. Collaboration with the entire team of caregivers.
5. Sensitivity and response to diversity to incorporate differences into patient care.
6. Facilitation of learning to ensure patients and families know how to continue care.
7. Clinical inquiry, including questioning and evaluation of practices to provide the best possible care.
8. Systems thinking to take a holistic approach to every care giving situation.

D. Patient Characteristics:
1. Participation in decision making about treatment options.

2. Involvement in care.
3. Level of stability (critical, fair, and stable).
4. Complexity of the illness or injury.
5. Resiliency of the patient.
6. Vulnerability or susceptibility to stressors of all types.
7. Availability of resources, including support systems upon discharge.
8. Predictability of the illness or injury.

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
   1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
   1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
   1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:
   1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
   1. The RN implements the plan
   2. Coordination of Care:
      a. The RN coordinates care
   3. Health Teaching& Health Promotion:
      a. The RN employs strategies to promote health and a safe environment
   4. Consultation:
      a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
   1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.

B. Is aware of own positive and negative biases and limitations.

~~C. Submits scheduling requests for Paid Time Off (PTO), per unit guidelines~~

~~A. Call-in for unscheduled absences per policy/procedure.~~

~~D.~~**C.** Has self confidence in own expertise.
~~Resource for new staff.~~

~~E.~~**D.** Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.

~~F.~~**E.** Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.

~~G.~~**F.** Accesses current nursing journals on research, best practices, technology and innovations.

~~H.~~**G.** Actively participates in unit retention strategies.

~~I.~~**H.** Embraces opportunities to preceptor,~~ and~~ mentor colleagues, **and students,** sharing learning **to further the practice of nursing.**~~ and is open to new processes and practices~~

~~J.~~**I.** Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.

B. Each department has a formalized staffing grid which is reviewed at ~~bi~~annually based on the following: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.

C. The Hospital and CNA bargaining unit will meet annually to validate the acuity assignment process.

XII. DELIVERY OF NURSING CARE

~~D.~~**A.** ~~There~~ Area**s** ~~seventeen (17) areas~~ where nursing care is delivered **under the Division of Nursing (including but not limited to)**:

~~i. Medical & SurgicalRehabilitation~~
~~b. Oncology~~
~~i. Medical Monitoring~~
~~ii. Behavioral Health Services~~
~~iii. Cardiology Services~~
~~iv. Emergency Services~~
~~v. Home Health~~
~~vi. Infusion Centers~~
~~vii. Intensive Care Unit~~
~~viii. Neonatal Intensive Care Unit~~
~~ix. Forensic Unit~~
~~x. Radiology Services~~
~~xi. Surgical Services~~
~~xii. Telemetry~~
~~xiii. Women's and Children's Services~~
~~xiv. Wound Care~~

1. Acute Care Services (1 North**, /Inpatient** Acute Rehabilitation **(ARU)**, 2 Pavilion, ~~3 Pavilion, 4~~ Pavilion~~, 3NS~~**):**
   a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.
      i. 1 North: Orthopedic diagnoses are emphasized.~~ as outlined in~~
      ~~i.~~**ii.** Inpatient Acute Rehabilitation (ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.
      ~~ii.~~**iii.** 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.
      ~~1) **3 Pavilion:** Closed~~

~~iii.~~**iv.** 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.

2. Behavioral Health Services/**Crisis Stabilization Unit**:
   a. The Behavioral Health Unit/**Crisis Stabilization Unit** develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of psychiatric disorders. This plan incorporates active interdisciplinary treatment teams consisting of psychiatric nurses and physicians, social services personnel, psychologists, mental health workers, and recreational therapists. The plan of care utilizes a variety of pharmacologic, behavioral, and psychotherapeutic interventions (groups and individual therapy) to restore optimal patient
3. Emergency Services:
   a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.
4. Home Health:
   a. The Home Health Department develops, implements, evaluates an**d** executes a comprehensive care plan for patients 18 years and older who meet the criteria. Home Health provides services for Medicare, Medi-Cal and contracted insurance companies. Home Health is Medicare certified and follows the guidelines of homebound status for Medicare. The plan of care is multidisciplinary which includes RN, **Licensed Vocational Nurse (**LVN**)**, **Certified Home Health Aid (**CHHA**)**, **Registered Diatition (**RD**)**, Physical and Occupational Therapy, Social Services, patient, family and caregivers as an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.
5. Infusion Center- Outpatient Hospital:
   a. The purpose of this area is to meet the needs of patients who require blood transfusions, antibiotic therapy, arthritic infusions, **and** IV infusions for dehydration. Offsite Outpatient infusion is for Chemotherapy.
6. Intensive Care Unit:
   a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older or weighing at least 35 kilograms with actual or potential life threatening medical or surgical conditions.
7. Neonatal Intensive Care Unit (NICU):
   a. The purpose of this unit is to develop, implement, and evaluate a plan of care for ~~newborn~~ infants **born prematurely and/or infants** who are critically ill~~ and need assistance and intervention to achieve an optimal transition to extrauterine life~~. **Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach.** This plan **emphasizes supportive, developmental and therapeutic care unique to the needs of each infant** ~~incorporates mutual interdisciplinary interactions while maintaining patient advocacy~~ and includes the ~~patient,~~ family~~,~~ **and/or designated family/infant support members** ~~and the nurse in response to psychological and physical needs~~.
8. **Progressive Care** ~~Forensic~~ Unit/**Specialty Clinic**:
   a. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved

individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.

- **i. Continuous Cardiac Monitoring (See Telemetry ~~Policy~~: Admission and Discharge Criteria Policy)**
- **ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)**
- **iii. Acute rehabilitation**
- **iv. Ante-partum care**
- **v. Post-partum care**
- **~~xv.~~vi. Medical-Surgical**

~~xvi. This is a 44 bed Locked unit that is under the division of nursing as well as the California Department of Corrections and rehabilitation. The Unit has 16 monitored bed capability for telemetry, a rehabilitation room for acute rehab and medical-surgical beds for general acute care.~~

9. **Perioperative/Perianesthesia** ~~Surgical~~ Services:
   a. Post-Anesthesia Care Unit (PACU):
      i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of **care to patients 14 years of age and older.** ~~patient care. All ages of patients are cared for in the PACU from pediatric patients through geriatric patients.~~
   b. Pre-Operative Hold:
      i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients **14 years of age and older,** and significant others~~, from pediatric patients through geriatric adult patients~~. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.
   c. Surgery:
      i. The purpose of Surgery/Operating Room is to provide surgical care to patients **fourteen (14) years of age and older** throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. **Most**~~All~~ surgical specialties are provided, including cardiac. There are no trauma or transplant services provided. ~~All ages of patients are treated in the operating room, from pediatric through geriatric adults.~~
   d. ~~Special Procedure Recovery Area (SPRA)~~**Outpatient Post-Anesthesia Care Unit**:
      i. The purpose of this area is to provide nursing care to patients ~~receiving outpatient infusions and/or~~ requiring recovery from outpatient interventional procedure**s or stage two recovery (when needed)**~~s~~. Nursing care is provided to deliver a safe, effective and appropriate level of patient care.
   e. Preoperative Education (Outpatient Service Center):
      i. **The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure.**

Patients may either have face to face visits, or a telephone call for assessment and education.

10. Telemetry **(2 East, 2 West, 4 East, 4 West and 3 Pavilion)**:
    a. The purpose of Telemetry is to develop, implement, and evaluate the Plan of Nursing Care for all clients. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, arterial line monitoring, chronic mechanical ventilation, mechanical ventilator weaning, or patients requiring intensity of service which cannot be provided in the acute care setting.
11. Women~~'s~~ and **Newborn**~~Infant~~ Services:
    a. The Women~~'s~~ and **Newborn**~~Children's~~ Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.
12. **Wound Care (Inpatient and Outpatient):**
    a. **The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure ~~that~~ anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.**

~~E.~~**B.** Areas where Nursing Care is delivered, not under the Division of Nursing:
1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.
2. Cardiac Catheterization Lab:
    a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.
3. Cardiac Rehabilitation:
    ~~c.~~**a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.**
4. Cardio~~ac~~vascular **Health** Institute:
    a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused

care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.

5. **Neurovascular Institute:**
   a. **The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.**
6. **Orthopaedic Institute:**
   ~~d.~~**a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.**
~~3.~~**7.** Interventional Radiology:
   a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that has evolved over the past 25 years to become an integral part of comprehensive nursing care, providing alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

~~XII.~~XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

A. A collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between departments providing patient care, patient services and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.

B. To facilitate effective interdepartmental relationships, problem-solving and shared decision making is encouraged at the point of service within the organization. Staff is encouraged to address one another's issues and concerns and seek mutually acceptable solutions. Supervisors and managers have the authority to solve problems and seek solutions within their span of control. Positive interdepartmental communications are strongly expected as part of our service standards.

C. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

~~XIII.~~XIV. REPORTING RELATIONSHIPS

A. **The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Manager. Each Director/Manager is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.**
   1. **Staff meetings shall be conducted by the Director/Clinical Manager or designee with a mechanism established for all staff members' participation.**
   2. **The Manager/ANM shall meet with their assigned Director/CNE at least monthly.**

~~1.~~**3. Directors/Managers shall ensure staff communication meetings are held at least monthly.**

4. Directors/ /Managers may attend the Medical Staff Division Meetings when appropriate.

B. The Chief Nurse Executive (CNE):

1. Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.

2. Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member.~~Executive Council~~.

3. Reports the status of the plan for Nursing Services to the **Clinical** ~~Patient Care~~ Quality Committee, and to Board of Directors.

4. A**ttends Medical Executive as the representative for the Department of Nursing.**

C. Patient Care Services Councils communicate with medical staff committees in the following way:

1. Quality reports to the Medical Quality/Peer Review Committee and QAPI.~~Medical Executive Committee (MEC)~~

2. CNE sits on the ~~reports to~~ Medical Executive Committee (MEC) as a non -voting member.

3. Medical Executive Committee reports to the Board of Directors (BOD)

~~XIV.~~XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured at least monthly and reported to the through QAPI and the Board annually. Areas of monitoring include but are not limited to:

1. **Comprehensive unit-based safety program** (CUSP) Projects
2. **Catheter-associated urinary tract infection (CAUTI)**
3. **Central line-associated bloodstream infection (CLABSI)**
~~2.~~**4.** Falls
~~3.~~**5.** Hand washing
~~4.~~**6. Hospital acquired condition** (HAC)
~~5.~~**7.** Medication Administration
8. Skin Care

B. **Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.**

~~XV.~~XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:

1. Patient requirements and their implications for staffing;
2. The hospital's ability to attract and develop staff;
3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
4. Feedback and specific concerns raised by patients, staff, and physicians.

B. In preparation for each fiscal year, the Department Director and/or Manager develop an operating and capital budget for each respective cost center and it is then submitted to the executive team and Board of Directors for final approval. Actual performance compared to the budget is reviewed regularly during the course of the fiscal year and is distributed to the department Director and/or Manager. A formal annual review of the effectiveness of the budgetary plan is made following the close of each fiscal year. Requests for capital equipment expenditures are initiated within each department/unit and are forwarded to the vice presidents, Chief Executive Officer, Chief Operating Office, Chief Nurse Executive, **Chief Financial Officer,** Chief Human Resources Officer, Chief Compliance Officer; for certain capital items, referral to the Board of Directors for final approval is required.

~~XVI.~~XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.

B. The Role of Nursing Leadership ~~i~~In Facilitating Excellent Nursing Care

1. We recognize the excellence delivered by our staff. As nurse leaders, we believe our critical role is making this excellence possible.
2. We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice, therefore; every attempt to ensure their attendance at Shared Decision-Making Council meetings is made.
3. Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines superb technical skill with an expert knowledge base. The professional nurse then needs an outstanding knack for communication-ease to achieve the best patient outcomes.

~~XVII.~~XVIII. NURSING SHARED-DECISION MAKING STRUCTURE

A. The Shared-Decision Making (SDM) structure shall be clearly defined through which the nursing staff will coordinate and integrate the delivery of nursing care. The SDM structure will recognize participation from all nursing staff members and will give evidence of shared decision making within the formal structure of the nursing staff.

B. The Purpose of ~~Shared Decision (~~SDM~~)~~:

1. To provide a structure that supports the point of care and sustains ownership and accountability at the point of service. This structure builds a culture for people to be together, to tell the story. It creates: shared meaning and purpose in work, healthy relationships and meaningful conversations. All staff is encouraged to begin to participate at the level that they are most comfortable with, and then to "spread their wings" as they become more familiar with the concept of SDM, feeling empowered to contribute to decisions and trust that the community of nursing embraces their contributions, it will flourish. Decisions are made through consensus. Proposed decisions are brought to the various nursing committees for discussion, revisions, approval or disapproval. Final decisions are based on research, evidence, regulations and/or best practices.

XIX. SHARED DECISION MAKING COMMITTEES

~~1.~~A. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.

~~2.~~1. The councils of the PCS areas operate under Shared Leadership.

a. A staff and management representative of the unit-based committees may participate in the councils

b. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty. (See Professional Nursing Governance Bylaws for detail).

~~a. There are ten (10) committees that will assume responsibility for the management, operation, and integration of the community of nursing.~~

~~B. Nursing Executive Committee (NEC)~~

~~1. Accountability~~

~~a. To transform the culture of nursing at TCMC. Provides the foundation (anchor) to link the communities of nursing into a group think process.~~

~~b. NEC will provide leadership to all other councils and serve as a clearinghouse for projects (Magnet) and issues, disseminating them to the appropriate Committees. Nursing Leaders will begin the dialogue process and provide communication role modeling throughout the organization.~~

2. Membership
   a. Membership includes Registered Nurse Directors from the Division of Nursing.
3. Responsibilities
   a. Oversee our Professional Practice Model and ensure effectiveness.
   b. Ensure integration of our Synergy, our care delivery model.
   c. Oversee nursing clinical quality outcome performance and ensure improvements in nursing sensitive outcomes.

C. Professional Practice
1. Accountability
   a. To assure the accountability of nursing practice for all issues, materials, activities and behaviors related to clinical practice. In addition, as a clearinghouse for interdisciplinary practices and processes, the committee will evaluate the appropriateness and effectiveness of patient care delivery across the continuum and make recommendations to the appropriate leaders.
2. Membership
   a. Membership includes: staff from each unit/department and an Advanced Practice Nurse representative, Director of Professional Practice, guests from multiple disciplines as requested.
3. Responsibilities
   a. To ensure adherence to the scope of practice of the professional nurse at TCMC
   b. To validate the role and responsibilities of patient care support staff at TCMC
   c. To provide input into job descriptions for clinical staff
   d. To review and recommend generic and unit specific competencies
   e. To review, approve and revise clinical standards of care, through consensus, where nursing care is delivered
   f. To establish an evaluating and peer review format for all nursing staff
   g. To incorporate nursing evidence and research findings into clinical practice
   h. To support and hold peers accountable to the patient care delivery model (SYNERGY) and system
   i. To collaborate with other healthcare disciplines on the development of processes across the continuum of care
   j. To participate in making recommendations for the nursing documentation system
   k. To participate in the implementation process of the career advancement model

D. Quality
1. Accountabilities
   a. To identify solutions to problems, improve practice and increase understanding of professional issues brought forth from staff, physicians, other disciplines or regulatory agencies. To establish a mechanism for non-punitive reporting.
2. Membership
   a. Members include selected staff and leaders from nursing.
3. Responsibilities
   a. To develop, revise and approve the nursing quality improvement plan
   b. To integrate nursing quality improvement with learning
   c. To endorse and monitor unit-based quality improvement plans
   d. To assure that appropriate quality health care is delivered to each person in a unique way.
   e. To allow staff an avenue to seek clarification on standards of performance and practice.
   f. To promote professionalism.
   g. To challenge professional practice standards that is not upheld throughout the Organization.
   h. To ensure that unexpected outcomes for care are evaluated, investigated and appropriate actions taken in accordance with the Code of Ethics.
   i. To evaluate outcomes of work redesign initiative

E. Patient Education Committee
1. Accountability
a. To identify opportunities for improvement in patient education materials (taking into account health literacy,) introduce new methodologies for teaching and learning, and comply with regulations.
2. Membership
a. Staff, educators and operational leaders.
3. Responsibilities
a. To ensure optimal patient education materials
b. To provide the opportunity for patient journaling
c. To assess literacy and educate to the patients level of understanding
d. To create and maintain an environment consistent with nursing management philosophy and our conceptual framework.
e. To collaborate with other departments, especially case management/discharge planning and disciplines to optimize patient and family compliance.

F. Clinical Policies & Procedures Committee
1. Accountability
a. The CPP Committee is charged with providing guidelines for the development, review, revision, and archiving of all policies and procedures, which are, applicable to patient care. All policies and procedures are to be reviewed every 3 years and revised as necessary. Standardized procedures are to be reviewed every 2 years and revised as necessary. Standards of care and professional practice, research, regulations, certifying bodies and best practices will all guide and impact our policy development. When there is disagreement on a policy and we have options to choose, we will do so by consensus. Specific committees and individuals will be consulted as appropriate.
2. Membership
a. Lead by an Advanced Practice Nurse and selected educators, leaders and staff from the Nursing Division, Laboratory and Pharmacy.
3. Responsibilities of Council
a. To monitor and ensure compliance with established standards of care
b. To collaborate with other disciplines to monitor and evaluate compliance with standards of care and make recommendations for continuous quality improvement
c. To monitor and ensure compliance with regulatory standards
d. To learn of compliance or deviance with standards at staff and interdisciplinary meetings
e. To give input, make recommendations, share evidence on work redesign initiatives

G. Wound Care
1. Accountability
a. To provide ongoing education, practice improvement and staff involvement in the identification, staging, care and proper documentation of wounds in the inpatient setting. Also provides a venue to review new products for wound and skin care and is the body that manages the prevalence studies.
2. Membership
a. Wound, Ostomy, Continence nurse (WOCN), Enterostomal Therapist (ET), managers, nurses, techs, Performance Improvement (PI) and educators from the entire patient care areas.
3. Responsibilities
a. Provide educational opportunities for the bedside nurse
b. Discuss practice issues and develop improvements
c. Review new products
d. Provide a support network for the bedside nurse

e. Review and develop policies and procedures
f. Organize and implement the prevalence studies on a quarterly basis
g. Increase awareness

H. Falls
1. Accountability
a. To identify problems, develop solutions, improve practice, and increase awareness in regard to patient falls in the inpatient areas.
2. Membership
a. Members include nursing administration and management, risk management, education, PI and facilities as well as staff nurses
3. Responsibilities
a. Increase awareness
b. Educate staff on an ongoing basis
c. Develop policies and procedures
d. Develop and implement preventative strategies
e. Analyze and monitor data and benchmarking
f. Review new fall prevention products
g. Support staff in fall prevention activities
h. Provide data to other committees
i. Review documentation for completeness and accuracy

I. Code Blue/Emergency Response
1. Accountability
a. To provide, within minutes, a multidisciplinary medical team approach using a formalized process, to assess and treat a patient, whose condition is deteriorating or when nursing staff on the floors has concerns related to patient's condition.
b. To provide support when a patient/family recognizes a noticeable medical change in condition and feels they are not receiving the appropriate response from the healthcare team.
c. TCMC will plan for, support, and coordinate a systematic approach to complex patients such as the implementation of the Rapid Response Team (RRT) to respond to deterioration in patient status outside the critical care setting.
d. The role of the Rapid Response Team is to:
e. Assess
f. Stabilize
g. Assist with communication
h. Educate and support
i. Assist with transfer to a higher level of care if necessary
2. Membership
a. Designated ICU RNs
b. Respiratory Care Practitioners
c. Pharmacy

3. Responsibilities
a. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
b. Reduce cardiac and/or respiratory arrests in the hospital
c. Reduce or more timely transfer to the Intensive Care Unit (ICU) or a higher level of care
d. Reduce patient intubations
e. Reduce number of hospital deaths
f. The ICU Nurse provides clinical expertise, advanced assessment skills and support for the patient's primary nurse, patient and patient's family, as well as facilitates a more timely transfer to a higher level of care when needed.

~~g. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the ICU Nurse, and assist in the care of the patient.~~

~~h. The Respiratory Care Practitioner (RCP) provides advanced respiratory assessment, immediate oxygen therapy, delivery of aerosolized medications, and assistance in delivering mechanical ventilation, through Non-Invasive Positive Pressure Ventilation (NIPPV) if required.~~

~~J. Research and Evidence-Based Practice (EBP)~~

~~1. Accountability~~

~~a. To define, implement and maintain educational standards that promote professional growth and ongoing clinical competency. To seek to define nursing care through the participation in clinical research and evidence-based data. The Research and EBP Committee is the oversight body for nursing research.~~

~~2. Membership~~

~~a. Director of Education, Education Specialists, Clinical Educators, Director of Professional Practice, Clinical Nurse Specialist, Staff Nurse Preceptors.~~

~~3. Responsibilities~~

~~a. To validate nursing knowledge~~

~~b. To generate new knowledge and make recommendations for change~~

~~c. To encourage and promote investigative practice~~

~~d. To promote nurses' individual accountability for mandatory education and facilitate credentialing/recertification~~

~~e. To foster an environment that allows for partnering with nursing support staff~~

~~f. To define, implement and maintain educational standards that promote professional growth and ongoing clinical competency. To seek to define nursing care through the participation in clinical research and evidence-based data. The Research and EBP Committee is the oversight body for nursing research.~~

~~K. Nursing Informatics Council (NIC)~~

~~1. Accountability~~

~~a. The Nursing Informatics Council is charged with providing guidelines and oversight for the development of any new nursing informatic solutions that are implemented at TCMC. Changes and/or revisions to current applications as well as the development of new applications are presented and approved by this committee.~~

~~2. Membership~~

~~a. Director of Education and Clinical Informatics, Clinical Nurse Analysts, IT Analysts, IT Application Manager, Nursing Department End-users, and Pharmacy Analyst.~~

~~3. Responsibilities~~

~~a. To assess and implement effective informatic solutions at TCMC.~~

~~b. To establish an evaluation and approval council for any nursing changes to clinical documentation.~~

~~c. To provide a mechanism for nursing end-user system requests to be evaluated and implemented.~~

~~d. To gain insight and feedback from nursing stakeholders regarding clinical documentation changes.~~

~~e. To provide an avenue to communicate and educate departmental stakeholders on nursing informatics changes.~~

~~f. To provide structure to review application implementation progress and quality data in order to revise or improve processes if necessary.~~

XX. RELATED DOCUMENT(S):

A. Patient Care Services: Chemotherapy Administration Procedure

B. Telemetry: Admission and Discharge Criteria Policy

~~XVIII.~~XXI. REFERENCES:

~~a. AACN Healthy Work Environment Standards~~
~~b. Hardin S. R. & Kaplow~~
~~A. Nursing Informatics: Scope and Standards of Practice, 2008~~
~~B.~~**A.** **American Nurses Association. (2015)** *Code of Ethics for Nurses* ***with Interpretive Statements*****. Washington, D.C.: American Nurses Publishing.** ~~2015~~0
~~C.~~**B.** **American Nurses Association. (2015)** *Nursing: Scope and Standards of Practice.*~~, 2015~~0
~~D.~~**C.** California Nurse Practice Act (2016)4
~~E.~~**D.** ~~Tim Porter~~ O'Grady, **T. P. (1999)** *Leading the Revolution in Health Care.*~~, 1999 pg~~ 164.

Tri-City Medical Center
Oceanside, California

CLEAN COPY

Plan for Nursing Care

I. **PURPOSE**

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services (PCS) are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements;
   2. The Hospital's recruitment, retention, and staff development capabilities;
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities;
   4. Evaluation of innovations and improvements in patient care;
   5. Affiliations, managed care contracts and reimbursement changes;
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues;
   7. The Hospital's Strategic and Facilities Plan and annual budget;
   8. Regulatory or accreditation changes;
   9. Collective Bargaining Agreement (CBA) revisions.

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. **DEFINITION OF NURSING**

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations. American Nurses Association, Scope of Practice, 2015 3rd Ed.

III. **NURSING VISION AND DISTRICT VALUES**

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City Healthcare District (TCHD).

B. The needs of our patients come first.

IV. **GUIDING PRINCIPLES**

A. We never lose sight of our patients' and families' needs and expectations.

B. We strive to make the most efficient use of our resources.

C. We are alert for opportunities to improve.

D. We encourage patients and families to participate in their care and decisions affecting their care.

E. We focus on team relationships and healthy interpersonal skills.

F. We enter into partnerships with patients, families, and other health care professionals eagerly.

Department Review	Clinical Policies and Procedures	Nurse Executive Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
07/16, 06/17	09/16, 07/17	09/16, 07/17	n/a	10/16, 08/17	09/17	

G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing, including but not limited to, the direct provision of care, establishing effective administrative systems, managing and delivering educational experiences, enhancing lifelong learning and supporting nursing research.

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at TCHD believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
   1. Caring - is the essence of nursing. A caring approach includes: knowledge, adaptable approaches based on the care-recipient's unique needs, patience, honesty, trust, humility, hope and courage.
   2. Diversity - is a core element for caring and leadership. It requires that the individual affirm his or her own unique self while learning to respect and address the needs of others who may have different values.
   3. Accountability - is the hallmark of professional practice. It requires responsibility to set personal standards for accomplishing expected goals, objectives and outcomes; for relationships and working together (collegiality); for supporting colleagues/peers; and for adherence to organizational policy and procedure.
   4. Integrity - is the foundation for clinical practice, leadership, and learning. It encompasses a commitment to people (staff, colleagues, families, community, and adherence to the professional nursing code of ethics and professional nursing standards of practice.
   5. Advocacy - is an inherent element of nursing ethics and nursing practice. As an advocate, the nurse is responsible for safeguarding, promoting, and supporting the patient's values and decisions.
   6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing, transcultural nursing care and leadership. Experienced nurses serve as mentors to others in assisting them to achieve a higher level of evidence-based practice.

VI. SCOPE OF PATIENT CARE

A. Patient care at TCHD encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. This care is provided collaboratively by health care providers with specialized knowledge, judgment and skill. Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers who recognize physical, psychological, and spiritual needs of patients.
   1. All PCS departments have a plan that describes their scope of service.

VII. PRACTICE STANDARDS

A. American Nurses Association Code of Ethics for Nurses 2015 2nd Ed.– Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at TCHD to use in ethical analysis and decision-making. The nine provisions of the Code of Ethics describe the most fundamental values and commitments of the nurse, boundaries of duty and loyalty and duties beyond individual patient encounters. These interpretive statements are not negotiable in any setting:
   1. Respect for Others
   2. Commitment to the Patient

3. Advocacy for the Patient
4. Accountability and Responsibility for Practice
5. Duty to Self and Duty to Others
6. Contribution to Healthcare Environments
7. Advancement of the Nursing profession
8. Promotion of Community and World Health
9. Promotion of the Nursing Profession

B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.

C. California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. TCHD nurses are responsible to be informed of these laws.

VIII. PATIENT CARE MODEL: SYNERGY™

A. TCHD Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.

B. The Synergy model delineates three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system.

C. Nurse Competencies:
1. Clinical judgment, including decision making, critical thinking and basic nursing skills.
2. Caring practices, responding to the unique needs of patients and families.
3. Advocacy to help identify and resolve concerns as they arise.
4. Collaboration with the entire team of caregivers.
5. Sensitivity and response to diversity to incorporate differences into patient care.
6. Facilitation of learning to ensure patients and families know how to continue care.
7. Clinical inquiry, including questioning and evaluation of practices to provide the best possible care.
8. Systems thinking to take a holistic approach to every care giving situation.

D. Patient Characteristics:
1. Participation in decision making about treatment options.
2. Involvement in care.
3. Level of stability (critical, fair, and stable).
4. Complexity of the illness or injury.
5. Resiliency of the patient.
6. Vulnerability or susceptibility to stressors of all types.
7. Availability of resources, including support systems upon discharge.
8. Predictability of the illness or injury.

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:
1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
1. The RN implements the plan

2. Coordination of Care:
   a. The RN coordinates care
3. Health Teaching& Health Promotion:
   a. The RN employs strategies to promote health and a safe environment
4. Consultation:
   a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
   1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.
B. Is aware of own positive and negative biases and limitations.
C. Has self confidence in own expertise.
D. Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.
E. Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.
F. Accesses current nursing journals on research, best practices, technology and innovations.
G. Actively participates in unit retention strategies.
H. Embraces opportunities to preceptor, mentor colleagues, and students, sharing learning to further the practice of nursing.
I. Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.
B. Each department has a formalized staffing grid which is reviewed at annually based on the following: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized in the Staffing Office and are kept in unit/departmental documents.
C. The Hospital and CNA bargaining unit will meet annually to validate the acuity assignment process.

XII. DELIVERY OF NURSING CARE

A. Areas where nursing care is delivered under the Division of Nursing (including but not limited to):
   1. Acute Care Services (1 North, Inpatient Acute Rehabilitation (ARU), 2 Pavilion, 4 Pavilion):
      a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.
         i. 1 North: Orthopedic diagnoses are emphasized.
         ii. Inpatient Acute Rehabilitation (ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions

requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.

iii. 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.

iv. 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.

2. Behavioral Health Services/Crisis Stabilization Unit:
   a. The Behavioral Health Unit/Crisis Stabilization Unit develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of psychiatric disorders. This plan incorporates active interdisciplinary treatment teams consisting of psychiatric nurses and physicians, social services personnel, psychologists, mental health workers, and recreational therapists. The plan of care utilizes a variety of pharmacologic, behavioral, and psychotherapeutic interventions (groups and individual therapy) to restore optimal patient
3. Emergency Services:
   a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.
4. Home Health:
   a. The Home Health Department develops, implements, evaluates and executes a comprehensive care plan for patients 18 years and older who meet the criteria. Home Health provides services for Medicare, Medi-Cal and contracted insurance companies. Home Health is Medicare certified and follows the guidelines of homebound status for Medicare. The plan of care is multidisciplinary which includes RN, Licensed Vocational Nurse (LVN), Certified Home Health Aid (CHHA), Registered Diatition (RD), Physical and Occupational Therapy, Social Services, patient, family and caregivers as an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.
5. Infusion Center- Outpatient Hospital:
   a. The purpose of this area is to meet the needs of patients who require blood transfusions, antibiotic therapy, arthritic infusions, and IV infusions for dehydration. Offsite Outpatient infusion is for Chemotherapy.
6. Intensive Care Unit:
   a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older or weighing at least 35 kilograms with actual or potential life threatening medical or surgical conditions.
7. Neonatal Intensive Care Unit (NICU):
   a. The purpose of this unit is to develop, implement, and evaluate a plan of care for infants born prematurely and/or infants who are critically ill. Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach. This plan emphasizes supportive,

developmental and therapeutic care unique to the needs of each infant and includes the family and/or designated family/infant support members.

8. Progressive Care Unit/Specialty Clinic:
   a. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
      i. Continuous Cardiac Monitoring (See Telemetry: Admission and Discharge Criteria Policy)
      ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)
      iii. Acute rehabilitation
      iv. Ante-partum care
      v. Post-partum care
      vi. Medical-Surgical
9. Perioperative/Perianesthesia Services:
   a. Post-Anesthesia Care Unit (PACU):
      i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of care to patients 14 years of age and older.
   b. Pre-Operative Hold:
      i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients 14 years of age and older, and significant others. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.
   c. Surgery:
      i. The purpose of Surgery/Operating Room is to provide surgical care to patients fourteen (14) years of age and older throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. Most surgical specialties are provided, including cardiac. There are no trauma or transplant services provided.
   d. Outpatient Post-Anesthesia Care Unit:
      i. The purpose of this area is to provide nursing care to patients requiring recovery from outpatient interventional procedures or stage two recovery (when needed). Nursing care is provided to deliver a safe, effective and appropriate level of patient care.
   e. Preoperative Education (Outpatient Service Center):
      i. The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure. Patients may either have face to face visits, or a telephone call for assessment and education.
10. Telemetry (2 East, 2 West, 4 East, 4 West and 3 Pavilion):
    a. The purpose of Telemetry is to develop, implement, and evaluate the Plan of Nursing Care for all clients. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, arterial line monitoring, chronic mechanical

ventilation, mechanical ventilator weaning, or patients requiring intensity of service which cannot be provided in the acute care setting.

11. Women and Newborn Services:
    a. The Women and Newborn Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.
12. Wound Care (Inpatient and Outpatient):
    a. The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.

B. Areas where Nursing Care is delivered, not under the Division of Nursing:
1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.
2. Cardiac Catheterization Lab:
    a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.
3. Cardiac Rehabilitation:
    a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.
4. Cardiovascular Health Institute:
    a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.
5. Neurovascular Institute:
    a. The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.

6. Orthopaedic Institute:
   a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.
7. Interventional Radiology:
   a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that has evolved over the past 25 years to become an integral part of comprehensive nursing care, providing alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

A. A collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between departments providing patient care, patient services and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.

B. To facilitate effective interdepartmental relationships, problem-solving and shared decision making is encouraged at the point of service within the organization. Staff is encouraged to address one another's issues and concerns and seek mutually acceptable solutions. Supervisors and managers have the authority to solve problems and seek solutions within their span of control. Positive interdepartmental communications are strongly expected as part of our service standards.

C. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

XIV. REPORTING RELATIONSHIPS

A. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/Manager. Each Director/Manager is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.
   1. Staff meetings shall be conducted by the Director/Clinical Manager or designee with a mechanism established for all staff members' participation.
   2. The Manager/ANM shall meet with their assigned Director/CNE at least monthly.
   3. Directors/Managers shall ensure staff communication meetings are held at least monthly.
   4. Directors/ /Managers may attend the Medical Staff Division Meetings when appropriate.

B. The Chief Nurse Executive (CNE):
   1. Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.
   2. Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member..
   3. Reports the status of the plan for Nursing Services to the Clinical Quality Committee, and to Board of Directors.

4. Attends Medical Executive as the representative for the Department of Nursing.

C. Patient Care Services Councils communicate with medical staff committees in the following way:
   1. Quality reports to the Medical Quality/Peer Review Committee and QAPI.
   2. CNE sits on the Medical Executive Committee (MEC) as a non -voting member.
   3. Medical Executive Committee reports to the Board of Directors (BOD)

XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured at least monthly and reported to the through QAPI and the Board annually. Areas of monitoring include but are not limited to:
   1. Comprehensive unit-based safety program (CUSP) Projects
   2. Catheter-associated urinary tract infection (CAUTI)
   3. Central line-associated bloodstream infection (CLABSI)
   4. Falls
   5. Hand washing
   6. Hospital acquired condition (HAC)
   7. Medication Administration
   8. Skin Care

B. Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.

XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:
   1. Patient requirements and their implications for staffing;
   2. The hospital's ability to attract and develop staff;
   3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
   4. Feedback and specific concerns raised by patients, staff, and physicians.

B. In preparation for each fiscal year, the Department Director and/or Manager develop an operating and capital budget for each respective cost center and it is then submitted to the executive team and Board of Directors for final approval. Actual performance compared to the budget is reviewed regularly during the course of the fiscal year and is distributed to the department Director and/or Manager. A formal annual review of the effectiveness of the budgetary plan is made following the close of each fiscal year. Requests for capital equipment expenditures are initiated within each department/unit and are forwarded to the vice presidents, Chief Executive Officer, Chief Operating Office, Chief Nurse Executive, Chief Financial Officer, Chief Human Resources Officer, Chief Compliance Officer; for certain capital items, referral to the Board of Directors for final approval is required.

XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.

B. The Role of Nursing Leadership in Facilitating Excellent Nursing Care
   1. We recognize the excellence delivered by our staff. As nurse leaders, we believe our critical role is making this excellence possible.
   2. We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice, therefore; every attempt to ensure their attendance at Shared Decision-Making Council meetings is made.
   3. Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines superb technical skill with an expert knowledge base. The professional

nurse then needs an outstanding knack for communication-ease to achieve the best patient outcomes.

XVIII. NURSING SHARED-DECISION MAKING STRUCTURE

A. The Shared-Decision Making (SDM) structure shall be clearly defined through which the nursing staff will coordinate and integrate the delivery of nursing care. The SDM structure will recognize participation from all nursing staff members and will give evidence of shared decision making within the formal structure of the nursing staff.

B. The Purpose of SDM:

1. To provide a structure that supports the point of care and sustains ownership and accountability at the point of service. This structure builds a culture for people to be together, to tell the story. It creates: shared meaning and purpose in work, healthy relationships and meaningful conversations. All staff is encouraged to begin to participate at the level that they are most comfortable with, and then to "spread their wings" as they become more familiar with the concept of SDM, feeling empowered to contribute to decisions and trust that the community of nursing embraces their contributions, it will flourish. Decisions are made through consensus. Proposed decisions are brought to the various nursing committees for discussion, revisions, approval or disapproval. Final decisions are based on research, evidence, regulations and/or best practices.

XIX. SHARED DECISION MAKING COMMITTEES

A. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.

1. The councils of the PCS areas operate under Shared Leadership.
   a. A staff and management representative of the unit-based committees may participate in the councils
   b. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty. (See Professional Nursing Governance Bylaws for detail).

XX. RELATED DOCUMENT(S):

A. Patient Care Services: Chemotherapy Administration Procedure
B. Telemetry: Admission and Discharge Criteria Policy

XXI. REFERENCES:

A. American Nurses Association. (2015) *Code of Ethics for Nurses with Interpretive Statements*. Washington, D.C.: American Nurses Publishing.
B. American Nurses Association. (2015) *Nursing: Scope and Standards of Practice*.
C. California Nurse Practice Act (2016)
D. O'Grady, T. P. (1999) *Leading the Revolution in Health Care*. 164.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**RIGID LARYNGOSCOPE REPROCESSING PROCEDURE**
Purpose:	Establish a standard practice for reprocessing of contaminated **reusable** rigid laryngoscope handles and blades after use during intubations.
Supportive Data:	~~Department of Health Services recommendations for reprocessing of semi-critical instruments such as rigid laryngoscopes dated April 30, 2007, AFL 07-09.~~ ~~Infection Control Policy, IC.5 – *Standard and Transmission Based Precautions*~~ ~~Infection Control Policy, IC.8 – *Hand Hygiene*~~
Equipment:	~~1. Intubation Trays~~ ~~2. Rigid Laryngoscope handle & blades~~ ~~3.~~1. Plastic Ziplock bag ~~4.~~2. Personal Protective Equipment (PPE)

A. **DEFINITION(S):**

1. Semi-Critical Medical Instruments: Instruments that contact mucous membranes or non-intact skin, but are not intended to penetrate sterile tissue. Items directly attached to instruments that contact mucous membranes, such as the handles of rigid laryngoscopes, should be considered semi-critical instruments.
2. Intubation Trays: Specially prepared trays with all necessary emergency equipment needed for intubation prepared by the Sterile Processing Department (SPD).
3. Laryngoscope: Any of several types of tubes, equipped with electrical lighting, used in examining or operating upon the interior of the larynx through the mouth.
4. Laryngoscope handles: Handheld battery-powered, fiber-optic light source for use in intubation.
5. Laryngoscope blades: Assorted size laryngoscope blades that attach to the Laryngoscope handles for use during intubation.

B. **PROCEDURE:**

1. Contaminated **reusable** rigid laryngoscope~~s~~ **handles and blades** shall be processed as soon as possible after use.
   a. Prolonged delay between use of the laryngoscope and reprocessing may result in the drying and hardening of debris on the laryngoscope's surfaces.
   b. Designated personnel are responsible to return and exchange trays in SPD.
2. The handle and blade shall be transported in an enclosed zip-lock bag or plastic container to the dedicated decontamination area for reprocessing.
3. The designated transporter delivers the tray to the processing area for decontamination.
4. The tray is checked for contamination and is cleaned using **hospital approved disinfectant**~~Sani-clothes~~.
5. Sterile items on the tray are inspected for package integrity. Items suspected of possible contamination shall be disposed.
6. Remove batteries and bulb from the laryngoscope handle.
7. Clean the blade and handle using an enzymatic cleaner.
   a. Blades and handles must undergo a minimum of high-level disinfection. The reprocessing of the device must take into consideration the manufacturer's recommendation, the type of material (if it is able to withstand the reprocessing method), and the infection risk to the patient.
8. **Place reusable laryngoscope handles and blades in a basket**
~~a.~~**9. Place basket in the washer/disinfector and run at the pre-set cycle for instruments**
~~8.~~**10. For**~~**I**~~**f** steam sterilization ~~is used~~, place the **reusable laryngoscope handles and blades** ~~blade and the handle~~ in individual peel packs **and run the cycle following the manufacturer's recommendations.**~~.~~

Department Review	Clinical Policies & Procedures	~~Operations~~ Nurse Executive Council	Pharmacy & Therapeutics Committee	Infection Control Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
12/07, 10/10; 01/15	10/10; 02/15, 11/16	11/10, 01/17	n/a	03/17	11/10, 05/17, 08/17	01/11, 09/17	01/11

~~9.~~**11.** The bulb and batteries are reinstalled **into the laryngoscope handle** and ~~the blades are~~ tested before placing ~~back~~ **into a peel pack and placed** in the tray.

a. This process is performed using clean technique to avoid recontamination of equipment.

~~10.~~**12. Single-use disposable handles and blades will be disposed of at point-of-use following the manufacturer's recommendations.**

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

1. **Infection Control Policy: Hand Hygiene - IC.8**
2. **Infection Control Policy: Standard and Transmission Based Precautions - IC.5**

D. **REFERENCES:**

1. **Association for the Advancement of Medical Instrumentation. ST79**
2. **Department of Health Services Recommendations for Reprocessing of Semi-Critical Instruments Such as Rigid Laryngoscopes. April, 30th 2007. AFL 07-09**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/11	**SUBJECT:** Skin Preparation, Surgical/Procedural
REVISION DATE: ~~12/13~~02/17	**POLICY NUMBER:** IV.V

Department Approval:	03/17
Clinical Policies and Procedures Approval:	~~12/13~~03/17
Nurse Executive Committee Approval:	~~12/13~~03/17
Operating Room Committee Approval:	04/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~02/14~~05/17~~08~~/17
Professional Affairs Committee Approval:	~~03/14~~09/17
Board of Directors Approval:	03/14

A. **PURPOSE:**
1. To provide guidelines for surgical/procedural site skin antisepsis.

B. **POLICY:**
1. The surgical/procedural site and the surrounding area shall be free of dirt, ~~and~~ debris, **emollients, and cosmetics** before surgical preparation.
2. The surgical/procedural site shall be assessed before skin preparation.
   a. Presence of lesions, rashes, warts or other skin conditions at the surgical/procedural site shall be documented and the surgeon shall be notified.
   b. Jewelry or body piercings should be removed before skin preparation.
3. Hair at the surgical site should be left in place whenever possible. If the presence of hair will interfere with the surgical procedure and removal is necessary, the following precautions shall be taken:
   a. Hair removal shall be performed as close to the time of surgery as possible.
   b. Hair removal at the surgical/procedural site shall be performed according to physician orders.
   c. Hair removal shall be done in a manner that preserves skin integrity.
      i. Electric or battery-powered clippers with a disposable or reusable head that can be disinfected between patients is preferred.
      ii. Razor use is strongly discouraged, but if used wet shaving is preferable to dry shaving.
      ~~ii.~~**iii. A sterile razor may be used by the surgeon to remove hair from the scrotum for scrotal procedures and implant cases involving the scrotum. The surgeon shall be provided a sterile razor and supplies to complete a wet shave.**
4. The surgical/procedural site and surrounding area shall be prepared with a Food & Drug Administration (FDA)-approved antimicrobial agent in accordance with manufacturer's written instructions.
   a. Selection of antimicrobial agents shall be based on patient allergy or sensitivity, incision location, skin condition, and physician preference.
   b. Skin antiseptics shall be used in the full concentration as packaged by the manufacturer; do not dilute skin antiseptics prior to use.
   ~~b.~~**c.** The surgical/procedural site shall be prepared by personnel who are knowledgeable about the patient and have demonstrated competency in skin preparation techniques.

i. Preps shall be performed by a Registered Nurse (RN) or Physician/**Allied Health Professional (AHP)**.

~~ii.~~**I.** Advanced Care Technicians (ACTs), ~~n~~**N**ursing ~~a~~**A**ssistants, ~~a~~**A**nesthesia ~~t~~**T**echnicians or ~~s~~**S**urgical ~~t~~**T**echnicians may prep under the direct supervision of an RN or ~~p~~**P**hysician/**AHP**.

d. Personnel performing surgical skin antisepsis shall wear sterile gloves and use sterile supplies to apply antiseptic agents.

~~c.~~**e.** Anti~~microbial~~**septic** agent**s** shall be applied using aseptic technique and proceeding from the incision site to the periphery.

i. Highly contaminated areas (eg, anus, colostomy) near the surgical site should be isolated with a sterile barrier drape.

~~i.~~**ii.** If a highly contaminated area is part of the procedure, the area with a lower bacterial count is prepped first, followed by the area of higher contamination.

~~ii.~~**iii.** An intestinal or urinary stoma within the surgical field should be cleansed gently and separately from the rest of the prepped area.

~~iii.~~**iv.** When prepping the anus, vagina, or a stoma, sinus, ulcer, or open wound, the sponge should be applied once to the area and then discarded.

~~iv.~~**v.** Vaginal preps for procedures that include the abdomen should be performed in a manner to prevent splashing of antiseptic agent expelled from the vagina onto the prepped abdomen.

I. Vaginal preps, inclusive or exclusive of Foley catheter insertion, are started and finished by the same RN. The vaginal prep sponges are removed from the vagina prior to disposal of prep supplies/~~f~~**F**oley catheter supplies, to prevent unintentional retention of the vaginal prep sponges.

5. Skin preparation shall be done in a manner that preserves skin integrity and prevents injury.
   a. Antimicrobial agents shall not be allowed to pool beneath the patient, tourniquets, **electrocardiography (ECG) electrodes,** positioning equipment, or electrosurgical dispersive pad.

6. Skin antiseptics shall be stored in the original, single-use container.

~~6.~~**7.** Special Considerations for Alcohol Based Prep solutions:
   a. Sufficient time must be allowed for the solution to dry and vapors to dissipate before the surgical drapes are applied and any heat source is used.
      i. Heat sources include: Electrosurgery, cautery, laser, burrs, drills, defibrillators, and light cords.
      ii. Verify in a "time out" before starting the procedure to assure the above condition is met.

~~7.~~**8.** Skin preparation agents shall not be warmed prior to application.

~~8.~~**9.** Patient skin preparation and skin condition shall be documented in the Perioperative/Procedural record.

C. **REFERENCE(S):**

1. ~~AORN Perioperative Standards and Recommended Practices, 2011 Edition.~~**AORN Guidelines for Perioperative Practice, 2016 Edition.**

~~1.~~**2. Patient Care Services: Sterile Technique**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**UNIVERSAL PROTOCOL**
Purpose:	To outline the requirements and the process of Universal Protocol for surgical and invasive procedures. This procedure is designed to enhance patient safety by ensuring proper identification of the patient and that the correct invasive or surgical procedure is performed on the correct side and at the correct site. Procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation.

A. **DEFINITION(S):**

1. Invasive Procedure: The puncture or the incision of the skin, insertion of an instrument or insertion of foreign material into the body for diagnostic or treatment-related purposes. For purposes of this policy, excluded as invasive procedures are~~:~~ venipuncture, **arterial puncture for lab draw,** nasogastric tube **placement,** ~~and~~ urethral catheter placement, **and** peripheral IV.
2. Patient Safety: In all cases the goal of the Universal Protocol is patient safety. To that end, the site marking or time out may be deferred if the risk outweighs the benefit to the patient in a life-threatening situation.
3. Pre-Procedural Verification: The process of assuring ~~that~~ all relevant and needed documents (e.g. history and physical, signed procedure consent form, informed consent documented by physician, physicians orders, surgery/procedure schedule, nursing assessment, pre-anesthesia assessment, labeled diagnostic and radiology test results, scans, ~~and/or~~ pathology and biopsy reports, and any required blood products, implants, devices, and/or special equipment for procedure), information and equipment are available prior to the start of the procedure, correctly identified, labeled and matched to the patient's identifiers, and are reviewed and consistent with the patient's expectations and team's understanding of the intended patient, procedure, site and side.
4. Site Marking: For purposes of this procedure, site marking is when the ~~Licensed Independent Practitioner (LIP)~~ **physician/Allied Health Professional (AHP)** who has been granted privileges to perform the procedure and will be directly involved in the procedure places his/her initials at the intended site of the procedure. Marking the site may also be done by use of a special purpose armband when it is not possible/feasible to mark the actual site.
5. Time Out: For purposes of this procedure, the Time Out means that after the induction of anesthesia or administration of any pre-procedure medication (as applicable),~~ and~~ completion of prepping and draping, **and** just prior to the start of the procedure (injection of local anesthesia, insertion of instrument or device, **and/or** incision), the staff involved with the procedure cease all other noise and activities (to the extent possible without compromising patient safety) and conduct the final assessment that the correct patient, site and procedure are identified.

B. **POLICY:**

1. The pre-~~-~~operative/pre-procedure verification process occurs with the patient **is** awake and aware if possible (as applicable):
   a. At the time the surgery/procedure is scheduled
   b. At the time of preadmission testing/assessment~~.~~
   c. At the time of admission
   d. Before the patient leaves the unit/floor
   e. In Pre-Op Hold/pre-procedure area
   f. Prior to transporting the patient to the operating/procedural room
   g. Anytime the responsibility for care of the patient is transferred to another member of the surgical/procedural care team (including anesthesia providers), at the time of and during the surgery/procedure

Department Review	Operating Room Committee	Clinical Policies & Procedures	Nursing Executive Council	Medical Executive Committee	Professional Affairs Committee	Board of Directors
10/08, 01/09, 09/09, 06/10, 07/12, 03/13, 09/14, **02/17**	**10/14, 05/17**	08/12, 07/13, 04/14, 10/14, **06/17**	08/12, 04/14, 10/14, **07/17**	10/12, 06/14, 11/14, **08/17**	11/12,07/14, 01/15, **09/17**	12/12, 07/14, 01/15

2. A Time Out is performed for every surgery and invasive procedure, regardless of laterality, levels, structure, location, or setting within the hospital, including bedside procedures. Any discrepancy discovered during the time out must be resolved before **proceeding with** the invasive procedure/surgery ~~to proceed~~.
3. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
   a. Discrepancies include any difference between the patient's verbal confirmation of the surgery/procedure to be performed, the H&P, order for consent, surgery/procedural schedule, consent and imaging studies.
   b. Members of the huddle may include, but are not limited to:
      i. ~~LIP~~ **Physician/AHP** performing the procedure
      ii. Anesthesiologist
      iii. Radiologist/Radiology Physician's Assistant
      iv. Circulating Registered Nurse (RN)
      v. Scrub RN or Operating Room (OR) Technician
      vi. RN caring for the patient in the pre-procedural area
      vii. Primary RN
      viii. Patient/patient representative
      ix. OR/Pre-procedural area charge nurse
      x. Imaging technologist
      xi. ~~Or~~ Other healthcare provider (HCP) involved **in** the procedure
   c. The following documents are reviewed in the huddle:
      i. H&P
      ii. Order for consent
      iii. Surgery/procedural schedule (if add on for the same day, no printed schedule is required)
      iv. Consent form
      v. Radiologic studies as ordered
   d. The procedure shall not progress until all discrepancies are resolved.
   e. The discussion resolving the discrepancy and the final result of the decision shall be documented in the medical record by one of the following:
      i. ~~LIP~~ **Physician/AHP** performing the procedure
      ii. RN/Healthcare Provider
      iii. Anesthesiologist (as applicable)

C. **SITE MARKING:**

1. Process:
   a. Prior to leaving Pre-Op Hold or the pre-procedure area, the intended surgical site is marked by the ~~LIP~~ **physician/AHP** performing the procedure. Site marking must be legible, unambiguous, used consistently throughout hospital, and be visible once the patient is prepped and draped.
      i. Outpatient areas without pre-procedure areas will perform site marking in the procedure room.
   b. Site marking is required for all surgeries and invasive procedures except:
      i. Emergency situations where any delay in initiating the surgery or invasive procedure would compromise the safety of the patient or~~f~~ outcome of the procedure.
      ii. Single organ procedures without intended laterality.
      iii. Procedures that are intended to be bilateral and no laterality-based choice is involved.
      iv. There is no pre-determined site of insertion (i.e. cardiac catheterization, Interventional Radiology procedures).
      v. The site is so clearly evident (i.e. open fracture, laceration, cast) that it cannot be confused.

vi. The ~~LIP~~ **physician/AHP** performing the procedure is in continuous attendance of the patient from the point of decision to perform the procedure through the completion of the procedure.
vii. Endoscopic procedures and Bronchoscopies.

c. Site marking takes into consideration laterality, surface (i.e. flexor/extensor), level (spine) or specific lesion/digit to be treated.
d. The mark is made using a marker that is sufficiently permanent to remain visible after skin prep and the mark is to be placed such that it is visible after the patient is prepped and draped.
e. The mark is made using the **physician/AHP**~~LIP~~'s initials.
   i. First and last initials are used. If the first and last initials are "N.O." a third initial is used.
   ii. The ~~LIP~~ **physician/AHP** may choose to also draw a line at the proposed incision site.
f. In the event of multiple primary procedures by different ~~LIP~~ **physician/AHP**'s, each site must be marked prior to admission to the OR/Procedural area.
g. The site marking should be done with the patient/family awake and involved, to the extent possible.
h. For minimal access procedures intended to treat a lateralized internal organ, the intended side is indicated by a mark at or near the insertion site.
i. Marking for procedures performed at the patient's bedside will occur prior to prepping/draping or starting the procedure.

2. For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative radiographic techniques may be used for marking the exact vertebral level.
3. Dental Procedures: The operative tooth name(s), ~~and~~ number(s) **and/**or letter(s) are indicated on the documentation (OR schedule, **H&P/P**~~P~~**p**lan for ~~S~~**s**urgery, ~~O~~**o**rder for ~~C~~**c**onsent) and the operative tooth/teeth are marked with the ~~surgeon's~~ **physician's/AHP's** initials on the dental radiographs or dental diagrams. The radiograph/diagram is posted in the procedure room prior to start of the procedure.
4. Nerve blocks: Anesthesia shall confirm the surgical/procedure site, through a comparison of the patient's verbal response and a review of the medical record and ~~P~~**p**rocedural ~~C~~**c**onsent form, prior to the administration of sedation and/or initiation of a nerve block. The Anesthesiologist may place a pre-surgical nerve block only after the surgical site has been marked by the ~~LIP~~ **physician/AHP**.
5. Special Use Armband**:**
   a. A special use armband is used when the surgical site is required to be marked, but cannot be marked because of one of the following situations:
      i. The patient refuses~~.~~
      ii. The patient is a neonate~~.~~
      iii. The proposed site is technically or anatomically difficult to mark (e.g., perineum)
      iv. Movement of the patient to mark could compromise the safety of the patient or outcome of the procedure (e.g. patient with unstable spine fracture)~~.~~
   b. The first and last name of the patient, a second patient identifier, and the planned procedure, including site and side, are written on the armband. In the event of laterality, the armband is applied on the side of the intended procedure.
   c. The ~~LIP~~ **physician/AHP** must initial the armband.
   d. The armband is removed at the conclusion of the procedure or immediately prior to prepping if necessary to perform the surgical/procedural prep on the banded limb.

D. **SCHEDULING:**

1. Scheduling for the procedure must include the following information:

a. Patient name and second patient identifier (DOB, MRN, or FIN). Cases cannot be scheduled unless this information is available (with the exception of an emergency, when a delay procuring information could adversely affect the patient).
b. Entire procedure, exact site, level, digit and side/ laterality. No abbreviations may be used.
c. See department specific scheduling procedures for additional scheduling requirements.

E. **PRE-PROCEDURE VERIFICATION PROCESS:**

1. Upon admission, the patient's identity is verified by the person admitting the patient. An appropriate identification band is affixed to the patient's arm (or leg). See Patient Care Services Policy Identification, Patient.
2. Before the patient leaves the unit/floor the Registered Nurse (RN):
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic studies report (as applicable)
   b. Completes the pre-operative/pre-procedure checklist (as applicable).
   c. Ensures site marking is completed if patient is going directly to the operating room.
   d. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
3. In Pre-Op Hold/pre-procedure area the **pre-procedural** RN/HCP:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic report and images, as ordered~~.~~
   b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
   ~~c. Ensures necessary implants or special equipment is available.~~
   ~~d.~~**c.** Ensures site marking is completed.
   ~~e.~~**d.** Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
4. Prior to transferring the patient to the operating room/procedural area the OR/Procedural RN:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P – plan for surgery
      ii. Orders for consent
      iii. Consent form
      iv. Surgery/procedural schedule
      v. Radiologic report and images, as ordered~~.~~ (
   b. Reviews the Pre-Operative Checklist to ensure accuracy and completeness.
   c. Ensures necessary implants or special equipment ~~is~~**are** available.
   d. Ensures site marking is completed.

e. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.

F. **TIME-OUT:**

1. The Time Out is conducted immediately before starting the procedure.
2. During the Time Out, all other noise and activities in the room are suspended (to the extent possible, without compromising patient safety).
3. Use the medical record and patient armband to verify:
   a. Patients' identity verified using two patient identifiers per Patient Care Services: ~~Policy~~ Identification of Patients **Policy** and comparing two sources of identification (patient's armband, if visible, and medical record). If the armband is not visible during the Time Out, one of the following alternatives must be used:
      i. A patient identification band is placed on an exposed extremity (alterative wrist, ankle) and this band is used to confirm two patient identifiers during the Time Out.
      ii. Two team members confirm the patient identity (two identifiers) upon arrival to the surgical/procedural area. One of the team members must remain with the patient during the entire pre-procedural phase and confirm the patient identity during the Time Out.
      iii. Two team members confirm patient identity (two identifiers) upon arrival to the surgical/procedural area. The two patient identifiers are written on the white board in the procedure room and confirmed by the two team members. During the final Time Out, the team confirms patient identity against the information on the white board.
         1) This patient identification process shall be used in surgical services.
   b. ~~Surgeon/LIP~~**Physician/AHP** calls for the Time Out after the patient is prepped and draped.
   c. The circulating RN/assistive HCP (such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician)**:**
      i. Uses the consent form to read the patient's name, approved second identifier, and procedure. ~~The circulating RN/HCP~~
      ii. **V**erifies ~~that~~ the alcohol-based prep was allowed at least 3 minutes to dry and fumes ~~to~~ dissipate**d** before draping.
   ~~c.~~**d.** The anesthesiologist (if applicable, or circulating RN if no anesthesiologist present) states antibiotic administered, dose and time.
   e. **The circulating RN/assistive HCP ~~(such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician)~~:**
      i. Verifies antibiotic selection is appropriate to procedure
      ii. States antibiotic re-dosing interval
      iii. Sets a timer for 30 minutes less than the re-dosing interval (i.e., if the re-dosing interval is 2 hours, set the timer for 1 hour and 30 minutes)
   ~~d.~~**f.** The ~~surgeon/LIP~~**physician/AHP** states the intended procedure, verifies the site is marked **(if applicable)** and asks if all agree.
   ~~e.~~**g.** The scrubbed person states agreement and readiness for consented procedure.
   ~~f.~~**h.** All Staff members in the OR at the time of the time out must state "I Agree" or state their concern/discrepancy.
4. Initiation of the Time Out is the responsibility of the ~~surgeon/LIP~~**physician/AHP** performing the procedure.
5. The Time Out is conducted in a fail-safe mode:
   a. The surgery/invasive procedure is not started until all questions are resolved.
6. The time out includes all members of the procedural team who will be participating in the procedure at its inception.

7. The circulating RN or healthcare provider assisting the ~~LIP~~ **physician/AHP** is responsible for documentation of the Time Out in the patient's medical record.
8. If two or more procedures are being performed on the same patient, a Time Out is performed to confirm each subsequent procedure before it is initiated.

G. RELATED DOCUMENT(S):

1. **Patient Care Services: Identification of Patients Policy**

H. REFERENCE(S):

~~9.~~1. **JAMA Surgery (2017). Centers for disease control and prevention guideline for the prevention of surgical site infection, 2017. *JAMA Surgery*, E1-E8. doi: 10.1001/jamasurg.2017.0904**
2. **The Joint Commission (2017). *Hospital Accreditation Standards.* Illinois: Joint Commission Resources.**

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

TRACKED CHANGES

ISSUE DATE: 07/91

SUBJECT: MANDATORY REPORTING REQUIREMENTS

REVISION DATE: 12/91, 11/94, 02/95, 03/96, 04/97, 07/99, 06/02, 05/03, 07/09, 06/11

POLICY NUMBER: 8610-236

Department Approval:	**~~12/16~~04/17**
Administrative Policies & Procedures Committee Approval:	**~~02/15~~04/17**
Organizational Compliance Committee Approval:	**08/17**
~~**Medical Executive Committee Approval:**~~	
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent ~~serious~~ injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
2. This policy/procedure consists of the following areas for reporting **including but not limited to the following. See the Reporting Grid and the National Quality Forum List of Serious Reportable Events – 2011 for additional reporting areas**:
   a. Adverse ~~Unexpected~~ Events
   b. Sentinel Events
   c. Serious Reportable Events
   ~~c.~~**d.** Unusual Occurrences (Title 22)

~~d.~~**3. For Violence Against Hospital Personnel – see Administrative Policy: Assault and Battery Reporting Process 241.**

~~e.~~**4.** ~~**PURPOSE:** The purpose of this section is to describe the nature of a sentinel event and to provide a process for identifying, investigating, and reporting sentinel events.~~

B. **DEFINITION(S):**

1. **Adverse Events: A patient safety event that results in harm to a patient including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events.**

~~3. Near Miss/Close Call: A patient safety event that did not reach the patient; also called good catch.~~

~~a.~~**2.** Root Cause Analysis - is a process for identifying ~~the~~ basic or causal factor(s) ~~that~~ underl**ying**~~ies~~ variation in performance, including the occurrence or possible occurrence of a sentinel event.

3. **Sentinel Events: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.**
4. **Serious Reportable Events: as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.**

~~b.~~**5. Unusual Occurrences (Title 22): Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare, safety or health of patients, personnel or visitors.**

~~4.~~**6. Violence Against Hospital Personnel: acts of assault or battery against on-duty hospital personnel.**

~~5. Sentinel Event: is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation that for which a recurrence would carry a significant chance of a serious adverse outcome [sometimes referred to as a "near miss"].~~

~~a. The sentinel event definition includes any occurrence that meets any of the following criteria:~~

~~i. The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition, or;~~

~~ii. The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient's illness or underlying condition):~~

~~1) Suicide of any patient receiving care, treatment or services in a staffed around-the-clock care setting or within 72 hours of discharge~~

~~2) Unanticipated death of a full-term infant~~

~~3) Abduction of any patient receiving care, treatment or services~~

~~4) Discharge of an infant to the wrong family~~

~~5) Sexual abuse, including rape~~

~~6) Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities~~

~~7) Invasive procedure or surgery on the wrong patient, wrong procedure, or wrong site.~~

~~8) Unintended retention of a foreign object in a patient after surgery or other invasive procedure~~

~~9) Severe neonatal hyperbilirubinemia (bilirubin greater than 30 mg/dL)~~

~~10) Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or greater than 25% above the planned radiotherapy dose.~~

~~6. Near Miss is a term used to describe any process variation which did not affect the outcome but for which a recurrence carries a significant chance of serious adverse outcome.~~

~~**Serious Reportable Event — as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.**~~

~~7.~~C. POLICY:

~~a.~~**1.** It is the District's policy to investigate any sentinel event, **unusual occurrence,** ~~serious~~ adverse event, or serious **reportable even**~~"near miss"~~ from an interdisciplinary perspective and take action to reduce the risk of recurrence. ~~Each serious adverse event~~

~~i.~~**a. Each sentinel event, ~~unusual occurrence,~~ adverse event, and serious reportable event** will be intensively assessed through the use of the Root Cause Analysis (RCA) process. ~~An action plan, based on the RCA is developed to implement improvements to reduce risk; the action plan is implemented and the effectiveness monitored.~~

b. **Every effort will be made to include the physicians and staff involved in the incident in the RCA process.**

~~c. The Risk Manager or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, the monitoring of the effectiveness of the plan and reporting of progress to the Executive Council.~~

~~d.~~**c.** A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors **through**~~via the~~ Professional Affairs Committee (PAC) **and Board of Directors meeting**.

~~e.~~**d.** RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The ~~Sentinel Event~~ investigation and reporting process, including development of the RCA, is intended to remain within the bounds of ~~Medical Staff Peer Review, subject to all applicable protections from discovery, including Evidence Code § 1157 and~~ Attorney-Client and

Attorney Work Product privileges.

~~8. PROCESS:~~

~~a. Each **sentinel event, unusual occurrence, adverse event, and serious reportable event**potential sentinel event will be investigated to the extent necessary to determine all the relevant facts and circumstances. The Risk Manager or Senior Administrative Designee shall compare the facts and circumstances to the Sentinel Event definition, and make a preliminary determination whether the potential event appears to qualify as a sentinel event. In order to make this determination, the Risk Manager or **Regulatory Director**Senior Administrative Designee has the discretion to convene an Ad Hoc committee, composed of physicians, hospital staff and consultants, if necessary, to assist in determining if a sentinel event has occurred.~~

~~i. If the potential event is determined to qualify as a sentinel event, the RCA process commences immediately and shall be completed within 45 days of notification of the event.~~

~~1) If the potential event fails to qualify as a sentinel event, the matter may be closed or referred for additional study using performance improvement methods.~~

~~ii. The RCA shall be documented on a "Root Cause Analysis" form and made part of a permanent file to be maintained by the Risk Manager. The RCA shall not be filed in the Medical Record.~~

~~b. The RCA report's conclusions and recommendations, if any, shall be communicated to the involved departments/services for development of a plan of action or plan of correction.~~

~~c. The Director of Risk Management and/or the Director of Regulatory Compliance, or Senior Administrative Designee shall coordinate the implementation of the improvement or correction plan, .t The monitoring of the effectiveness of the plan and reporting of progress to the Administrative Team Meeting**will be reported to the Quality Assure Performance Improvement (QA/PI) Committee**.~~

~~9.~~D. REPORTING TIMEFRAMES:

~~a.~~**1.** The first person to identify an **incident**~~adverse event~~ will notify his/her supervisor as soon as it is safe to do so.

~~b.~~**a.** The supervisor must assure that **the incident**~~serious adverse events~~ **is**~~are~~ reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. The~~se~~ **CNE** will assure that the event is then reported to the Chief Executive Officer, **and** Chief Operating Officer~~, etc as appropriate~~ **prior to reporting to regulatory agencies**.

~~c.~~**2.** The patient's primary and/or involved physician**(s)** is notified.

~~2.~~**3.** Based on the **incident**~~circumstances~~, a decision will be made to report ~~the event~~ to the appropriate regulatory agenc**y**~~ies~~ **within the required timeframe**.~~All events requiring notification of regulatory agencies, such as the California Department of Public Health, will be completed in a timely manner.~~

~~a. The appropriate Medical Staff Leader for the department is notified.~~

~~B.~~E. COMMUNICATION:

~~a. Information related to the reportable event is communicated to the physician and staff involved in the care of the patient as soon as possible.~~

~~b. Physicians and staff involved in the reportable event may **will** be included in the RCA and Action Plan.~~

~~c. The appropriate Medical Staff Leader will be notified prior to reporting the event whenever possible.~~

~~d.~~**1.** Reported **incidents**~~events~~ are communicated to the appropriate medical staff Quality Review committees~~, the Medical Executive Committee,~~ and the Board of Directors.

~~e.~~**2.** **Incidents**~~Critical events~~ may be reported in an expedited manner by Administration via verbal or electronic methods.

~~A report of each RCA shall be communicated to the QA/PI/PS of the Medical Staff, for periodic reporting to the Board of Directors via the Professional Affairs Committee (PAC)~~**~~UNUSUAL OCCURRENCES (TITLE 22)~~**

~~DEFINITIONS:~~

~~Unusual Occurrence: (Title 22, Section 70736) – any condition or event which has jeopardized, or could jeopardize, the health, safety, security or well being of any patient, employee or any other person while in the facility. These shall include, but not be limited to the following:~~

~~An epidemic outbreak of any disease, prevalence of communicable disease, whether or not such disease is required to be reported by Title 17, California Administrative Code, Section 2500, or epidemic infestation by parasites or vectors~~

~~Poisonings~~

~~Fires~~

~~Physical injury to any person, which would require treatment by a physician~~

~~Death of a patient, employee or visitor from unnatural causes~~

~~Sexual acts involving patients who are non-consenting~~

~~Physical assaults on patients, employees or visitors~~

~~All instances of patient abuse~~

~~Actual or threatened walkout, or other curtailment of services or interruption of essential services provided by the facility~~

~~PROCEDURE:~~

~~In accordance with State of California standards, the following provisions have been established. An occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety or health of patients, personnel or visitors, shall be reported as soon as reasonably practical, either by telephone or by any other practical means to the local health officer and to the California Department of Public Health (CDPH) and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services.~~

~~The District shall furnish other pertinent information related to such occurrences as may be required by CDPH or health officers.~~

~~In the event of a disruption of services, the Administrator or designee shall be responsible for immediate reporting.~~

~~ADVERSE UNEXPECTED EVENTS:~~

~~PURPOSE:~~ ~~This section complies with the requirements of SB 1301 (CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4) mandating the reporting of "adverse events" to the California Department of Public Health (CDPH).~~

~~POLICY:~~

~~It shall be the policy of Tri-City Medical Center (TCMC) to report an adverse event, as defined in Health & Safety Code § 1279.1, to the CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services not later than 5 days after the adverse event has been detected; or, in the event of an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel or visitors, not later than twenty-four (24) hours after the adverse event has been detected. TCMC shall inform the patient or the party responsible for the patient of the adverse event by the time the report to CDPH is made.~~

~~PROCESS:~~

~~All adverse events shall be reported without delay to the Director of Risk Management and to the Director of Regulatory Compliance, or in their absence, to the COO, CNE, or in his/her absence, to the CEO for analysis and determination if such adverse event needs to be reported to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. The Director of Risk Management shall notify the attending physician(s) and the Chief of Staff, or his designee, that a report of a potential adverse event has been received. These physicians and the CEO, CNE,COO or their designees shall be consulted and provide input regarding the report ability of the event, so long as such consultation and input does not prevent timely reporting to CDPH and as applicable to county of San Diego Behavioral Health Services or the Department of Health Care Services. In the event that an adverse event qualifies for reporting to CDPH, the report shall be made on a form, specifically designed for such reporting and individually identifiable patient information shall be safeguarded, in terms of privacy and confidentiality, consistent with applicable law.~~

~~In every situation, the attending physician shall be the preferred individual to disclose the adverse event to the patient/family. Only where the attending physician is unable to or unwilling to make this disclosure will a Medical~~

~~Staff Officer, or some other designee, disclose the event to the patient/family. The date, time, and circumstances of disclosure shall be recorded in the patient's permanent medical record.~~
~~The Department Director/Manager/designee shall be notified of the event. In addition, if the patient is a research patient, the Director of Clinical Research shall be notified.~~
~~The Director of Risk Management is responsible for ensuring that a thorough investigation of the adverse event is completed, which may include a root cause analysis.~~
~~The adverse significant event shall be reported in the in the RL Solutions Incident Report.~~

~~CALIFORNIA STATE REPORTABLE ADVERSE EVENTS:~~
~~Surgical events, including the following:~~
~~Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.~~
~~Surgery performed on the wrong patient.~~
~~The wrong surgical procedure performed on a patient, which is a surgical procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.~~
~~Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.~~
~~Death during or up to 24 hours after induction of anesthesia after surgery of a normal, healthy patient who has no organic, physiologic, biochemical, or psychiatric disturbance and for whom the pathologic processes for which the operation is to be performed are localized and do not entail a systemic disturbance.~~
~~Product or device events, including the following:~~
~~Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the health facility when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.~~
~~Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.~~
~~Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a facility, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.~~
~~Patient protection events, including the following:~~
~~An infant discharged to the wrong person.~~
~~Patient death or serious disability associated with patient disappearance for more than four hours, excluding events involving adults who have competency or decision-making capacity.~~
~~A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility.~~
~~Care management events, including the following:~~
~~A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.~~
~~A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.~~
~~Maternal death or serious disability associated with labor or delivery in a low-risk pregnancy while being cared for in a facility, including events that occur within 42 days post-delivery and excluding deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy, or cardiomyopathy.~~
~~Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in a health facility.~~
~~Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.~~

~~A Stage 3 or 4 ulcers, acquired after admission to a health facility, excluding progression from Stage 2 to Stage 3 if Stage 2 was recognized upon admission.~~
~~A patient death or serious disability due to spinal manipulative therapy performed at the health facility.~~
~~Environmental events, including the following:~~
~~A patient death or serious disability associated with an electric shock while being cared for in a health facility, excluding events involving planned treatments, such as electric counter shock.~~
~~Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.~~
~~A patient death or serious disability associated with a burn incurred from any source while being cared for in a health facility.~~
~~A patient death associated with a fall while being cared for in a health facility.~~
~~A patient death or serious disability associated with the use of restraints or bedrails while being cared for in a health facility.~~
~~Criminal events, including the following:~~
~~Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.~~
~~The abduction of a patient of any age.~~
~~The sexual assault on a patient within or on the grounds of a health facility.~~
~~The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of a facility.~~
~~An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.~~
~~Serious Disability means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than 7 days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.~~

~~C.~~F. ATTACHMENT(S):

1. Reporting Grid
2. **National Quality Forum List of Serious Reportable Events 2011**

G. RELATED DOCUMENTS:

~~3.~~1. **Administrative Policy: Assault and Battery Reporting Process 241**

~~D.~~H. REFERENCES:

1. **CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4**
2. **California Code of Evidence Section 1157**
3. California Hospital Association Consent Manual 201~~4~~4
4. **Title 17**
5. **Title 22, Section 70736**

Reporting Grid

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Adverse Event (AE)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600--15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z , PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z , PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z , PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	–MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	**Policy: Clinical** Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

National Quality Forum
List of Serious Reportable Events - 2011

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or ~~serious~~ injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or ~~serious~~ injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or ~~serious~~ injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or ~~serious~~ injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in ~~serious~~ injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or ~~serious~~ injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or ~~serious~~ injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or ~~serious~~ injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or ~~serious~~ injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or ~~serious~~ injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or ~~serious~~ injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or ~~serious~~ injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or ~~serious~~ injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or ~~serious~~ injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based

practices, long-term care/skilled nursing facilities

5D. Patient death or ~~serious~~ injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or ~~serious~~ injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or ~~serious~~ injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

CLEAN COPY

ISSUE DATE: 07/91

SUBJECT: MANDATORY REPORTING REQUIREMENTS

REVISION DATE: 12/91, 11/94, 02/95, 03/96, 04/97, 07/99, 06/02, 05/03, 07/09, 06/11

POLICY NUMBER: 8610-236

Department Approval:	**04/17**
Administrative Policies & Procedures Committee Approval:	**04/17**
Organizational Compliance Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis. To identify and prevent injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.
2. This policy/procedure consists of the following areas for reporting including but not limited to the following. See the Reporting Grid and the National Quality Forum List of Serious Reportable Events – 2011 for additional reporting areas:
   a. Adverse Events
   b. Sentinel Events
   c. Serious Reportable Events
   d. Unusual Occurrences (Title 22)
3. For Violence Against Hospital Personnel – see Administrative Policy: Assault and Battery Reporting Process 241.

B. **DEFINITION(S):**

1. Adverse Events: A patient safety event that results in harm to a patient including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events.
2. Root Cause Analysis - is a process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.
3. Sentinel Events: A patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.
4. Serious Reportable Events: as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011.
5. Unusual Occurrences (Title 22): Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare, safety or health of patients, personnel or visitors.
6. Violence Against Hospital Personnel: acts of assault or battery against on-duty hospital personnel.

C. **POLICY:**

1. It is the District's policy to investigate any sentinel event, unusual occurrence, adverse event, or serious reportable even from an interdisciplinary perspective and take action to reduce the risk of recurrence.

a. Each sentinel event, adverse event, and serious reportable event will be intensively assessed through the use of the Root Cause Analysis (RCA) process.
b. Every effort will be made to include the physicians and staff involved in the incident in the RCA process.
c. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement/Patient Safety Committee (QA/PI/PS) of the Medical Staff, for periodic reporting to the Board of Directors through Professional Affairs Committee (PAC) and Board of Directors meeting.
d. RCAs shall not be reported to the Joint Commission, nor to any external agency or organization, except upon specific, written advice of legal counsel. The investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Attorney-Client and Attorney Work Product privileges.

D. **REPORTING TIMEFRAMES:**

1. The first person to identify an incident will notify his/her supervisor as soon as it is safe to do so.
   a. The supervisor must assure that the incident is reported the Director of Risk Management, Chief Nurse Executive, and the Director of Regulatory Compliance. The CNE will assure that the event is then reported to the Chief Executive Officer, and Chief Operating Officer prior to reporting to regulatory agencies.
2. The patient's primary and/or involved physician(s) is notified.
3. Based on the incident, a decision will be made to report to the appropriate regulatory agency within the required timeframe.

E. **COMMUNICATION:**

1. Reported incidents are communicated to the appropriate medical staff Quality Review committees and the Board of Directors.
2. Incidents may be reported in an expedited manner by Administration via verbal or electronic methods.

F. **ATTACHMENT(S):**

1. Reporting Grid
2. National Quality Forum List of Serious Reportable Events 2011

G. **RELATED DOCUMENTS:**

1. Administrative Policy: Assault and Battery Reporting Process 241

H. **REFERENCES:**

1. CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4
2. California Code of Evidence Section 1157
3. California Hospital Association Consent Manual 2016
4. Title 17
5. Title 22, Section 70736

Reporting Grid

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Adverse Event (AE)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy:Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600--15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z , PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z , PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z , PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	–MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	**Policy: Clinical** Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

National Quality Forum
List of Serious Reportable Events - 2011

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or injury associated with the use of physical restraints or bedrails while being

cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 01/07

SUBJECT: POLICY AND PROCEDURE APPROVAL ~~- ADMINISTRATIVE~~ PROCESS

REVISION DATE: 07/09, 07/12

POLICY NUMBER: 8610-240

Department Approval:	**07/17**
Administrative Policies & Procedures Committee Approval:	**~~07/15~~07/17**
Professional Affairs Committee Approval:	**~~08/15~~09/17**
Board of Directors Approval:	**08/15**

A. **PURPOSE:**

1. To define Tri-City Healthcare District's (TCHD) process for the approval of policies.

B. **DEFINITION(S):**

1. Policy/**Procedure**: ~~A policy is~~ a formal, approved, written description of how a governance, management, or clinical care process is defined, organized, or carried out. A policy covers broad principles or complex standards requiring Board/**Administrative** approval and may have significant legal, regulatory, or financial implications.
   a. Documents that may support the policy/**procedure;** ~~,~~ including but not limited to practices, ~~procedures,~~ pre-printed orders, and chart forms; ~~,~~ are not defined for the purposes of this policy.

C. **POLICY:**

1. **The electronic policy management system will be used for all policies and procedures.**
2. Policies/**procedures** are:
   - **a.** ~~Required~~ **To be** reviewed ~~/ or~~ revised **per** ~~every five (5) three years or as required by change in regulation~~ **regulatory requirements**, research, or organizational processes **and submitted through the approval process**.
     - **i. See Policies and Procedures Review Grid.**
     - ~~It is recommended that policies/procedures be reviewed / revised every three (3) years. Nursing policies and procedures are required to be reviewed every three (3) years per Title 22.~~
     - ~~Standardized procedures are required to be reviewed every two (2) years per California Board of Registered Nurses.~~
     - ~~Neonatal Unit policies are required to be reviewed per California Children Services (CCS).~~
     - ~~Laboratory.~~
     - ~~Interpretation policy required to be reviewed annually per the Joint Commission (JC).~~
     - ~~Environment of Care plans are required to be reviewed annually per the JC.~~
   - **~~a.~~b.** Developed in collaboration with the medical staff ~~:~~ if relevant to medical staff activities **and/or direct patient care**.
   - **~~b.~~c.** **Developed** ~~And~~ in collaboration with nursing leadership if relevant to direct patient care.
   - **~~a.~~d.** Consistent with professional references, applicable regulations, legal requirements, accreditation standards, and the mission and philosophy of the organization.
3. **Creating and revising documents:**

~~c.~~**a. The editable version (i.e. Word document) will be stored in the electronic policy management system.**

b. Revisions to the documents will be tracked as changes while going through the approval process.

~~d.~~**c. Any changes to content, deletions, and/or combining of policies/procedures will require the full approval process.**

4. Approval:

~~b.~~**a. Policies/Procedures are submitted to the Board of Directors (BOD) or Administration for final approval.**

i. All policies are submitted to the Board of Directors for final approval.

ii. Procedures are submitted to the BOD or Administration for final approval based on regulatory requirements.

1) Nursing procedure must be approved by the BOD per Title 22

~~i.~~**iii.** Pre-approved by Board Committees prior to submission to the Board:

1) The Human Resource Committee **(HRC)** approves all administrative policies that relate to human resource issues.
2) The Finance, Operations, and Planning Committee **(FO&P)** approves all administrative policies that relate to finance issues.
3) The Audit, Compliance and Ethics Committee **(ACE)** approves all administrative policies that relate to compliance and privacy issues.
4) The Governance/Legislative Committee approves all policies that relate to the Board of Directors issues, Medical Staff By-Laws and Medical Staff Rules and Regulations.
5) The Professional Affairs Committee **(PAC)** approves all others.

b. Issue Date should be the first final approval date by BOD or Administration.

c. Revision dates should reflect final approval dates ~~every additional~~each time the policy/procedure is approved by the Board/Administration.

~~2.~~**d. The Department Manual Coordinating Committee will coordinate approval at Medical Staff Department/Division/Committees, Medical Executive Committee (MEC), Board Committees and the BOD.**

e. Staff shall be notified of any new policies/procedures or significant revisions. Education shall be provided as appropriate.

~~e.~~**f. A hard copy of all current policies/procedures must be available in the department for downtime.**

D. PROCESS FOR ADMINISTRATIVE MANUAL(S) APPROVAL:

1. Approval Process

a. Content Expert
b. Administrative Policies and Procedures Committee (APP)
c. Pharmacy and Therapeutics Committee (P&T), if contains medication, medication administration or if standardized procedure
d. MEC, if relevant to medical staff activities and/or direct patient care
e. Appropriate Board Committee
f. BOD

E. PROCESS FOR PATIENT CARE SERVICES (PCS) MANUAL APPROVAL:

1. Approval Process

a. Content Expert
b. Clinical Policies and Procedures Committee (CPP)
c. Nurse Executive Committee (NEC)
d. Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
e. P&T, if contains medication, medication administration or if standardized procedure
f. Interdisciplinary Practice Committee (IDPC), if a standardized procedure

g. MEC, if relevant to medical staff activities and/or direct patient care
h. PAC
i. BOD

F. PROCESS FOR DEPARTMENT SPECIFIC MANAUL APPROVAL:

1. Approval Process
   a. Content Expert
   b. Department Manager and/or Director
   c. Medical Director for clinical areas with a Medical Director when appropriate
   d. Medical Staff/Department Division, if relevant to medical staff activities or direct patient care
   e. MEC, if relevant to medical staff activities and/or direct patient care
   f. PAC
   g. BOD
2. Each Department is responsible for maintaining their own department specific manual.
   a. Makes revisions in the electronic policy management system to policies/procedures using tracked changes.
   ~~a.~~b. Obtain Medical Director's approval if applicable for policies/procedures related to Medical Staff activities or direct patient care.

G. RELATED DOCUMENT(S):

~~b.~~1. Policies and Procedures Review Grid

H. REFERENCE(S):

1. California Department of Public Health, Title 22 California Code of Regulations
2. The Joint Commission Standards
3. California Children's Services Standards
4. College of American Pathologists

Policies and Procedures Review Grid

Policies and Procedures Category	Policy/Procedure Name	Review Period	Regulation Requirement
Nursing Policies	All	3 Years	Title 22
Standardized Procedures	All	2 Years	California Board of Registered Nurses
Neonatal Unit Policies	All	2 Years	California Children Services (CCS)
Laboratory Policies	All	2 Years	College of American Pathologists (CAP)
Interpretation Policies	Patient Care Services: Interpretation and Translation Services Policy	Annual	Joint Commission (JC)
Environment of Care Plans	Engineering: Utility Management Plan	Annual	Joint Commission (JC)
	Environment of Care: Hazardous Material and Waste Management and Communication Plan		
	Environment of Care: Life Safety Management Plan		
	Environment of Care: Safety Plan		
	Environment of Care: Security Management Plan		
Pharmacy: Sterile Pharmaceuticals and Hazardous Drugs	Pharmacy: Automatic Therapeutic Interchange	Annual	TCHD Pharmacy and Therapeutics Committee
	Pharmacy: Black Box Warnings, Drugs with Policy		
	Pharmacy: Sterile Products Preparation	Annual	United States Pharmacopeia (USP) <797>,<800>
Infection Control	Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11	Annual	Joint Commission (JC)
	Infection Control: Bloodborne Pathogen Exposure Control Plan		
	Infection Control: Risk Assessment and Surveillance Plan		

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Abuse Reporting Forms**
POLICY NUMBER: **700**

ISSUE DATE: **03/08**
REVISION DATE: **08/09, 06/10, 03/13**

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To ensure that all forms related to reporting abuse are properly completed and filed.

B. **POLICY:**
1. When it becomes necessary to report dependent adult abuse or neglect, the clinician will follow established hospital policy and will complete and file all relevant forms in a uniform and consistent manner.

C. **PROCEDURE:**
1. Social Services:
   a. When calling either Child Protective Services (CPS) or Adult Protective Services (APS) the name of the person contacted will be documented in the medical record.
   b. The original form will be mailed/faxed to the agency. **If the form is faxed, a fax confirmation must be obtained.**
   c. A copy of the form **along with the fax confirmation** will be forwarded to **Tri-City Healthcare District's (TCHD~~TCMC~~)** Case Management/**Social Service** office.
   d. No copies will be placed in the medical record.
2. Psychiatric Liaison Team:
   a. As with Social Services, the Psychiatric Liaison filing a CPS or APS report will document the name of the person contacted in the medical record.
   b. The original form will be mailed/faxed to the agency. **If the form is faxed, a fax confirmation must be obtained.**
   c. A copy of the form **along with the fax confirmation** will be forwarded to ~~the BHU Nurse educator who will forward it to~~ the **TCHD~~TCMC~~** Case Management/**Social Service** office.
   d. No copies will be placed in the medical record.

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: AHA: NON-TCHD~~TCMC~~ CLASS PARTICIPANTS

ISSUE DATE: 03/07
REVISION DATE(S): 04/10, 07/13

Department Approval:	**~~12/16~~03/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**07/13**

A. **PURPOSE:**
1. To utilize **Tri-City Healthcare District (TCHD)**~~TCMC~~**TCHD** existing education resources (AHA Instructors)
2. To practice fiscal responsibility and generate revenue.

B. **DEFINITION(S):**
1. Non-~~TCMC~~**TCHD** employee.
2. Basic Life Support Renewal (BLS), Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS). Full , Renewal, and Skills courses.

C. **POLICY:**
1. The ~~TCMC~~**TCHD** AHA Training Center (TC) coordinates the number and frequency of AHA courses based on information provided by **Human Resources**~~Res-Q database~~.
2. AHA scheduled courses not filled by ~~TCMC~~**TCHD** employees will be made available to Non-~~TCMC~~**TCHD** employees in order to manage staffing and prevent cancellation of TC Instructors.
   a. Courses will be made available to Non-~~TCMC~~**TCHD** employees 1 (one) week prior to BLS renewal course and one (1) week prior to ACLS courses.
3. Non-~~TCMC~~**TCHD** Employees must present a current AHA BLS/ACLS Provider and/or Instructor card from an approved AHA Training Center that is current and in good standing with the AHA guidelines and curriculum.
4. ~~TCMC~~**TCHD** TC will accept cards only from the American Heart Association's Healthcare Provider Online Renewal course if it included a complete Part II skills check from an authorized AHA Training Center.
5. ~~TCMC~~**TCHD** TC will utilize the Course Card Reference Guide for surveillance of AHA provider cards which is found in TC Coordinator's office.

~~1. Contact Education department for most current list of Training Centers in good standing with the AHA.~~

~~2.~~**6.** When a scheduled course does not have a complete participant allotment or if an opening exists due to cancellation of participants, ~~TCMC~~**TCHD** will offer the course to a requesting Non-Employee
   a. The Non-~~TCMC~~**TCHD** employee will be notified within one week for BLS courses and within 1 week for ACLS courses to allow for recommended course preparation
   b. The Non-~~TCMC~~**TCHD** employee candidate will adhere to the AHA guidelines for course preparation, utilizing the most current AHA course materials
   c. The Non- ~~TCMC~~**TCHD** employee confirms attendance and payment must be made in full upon enrolling, payment may be made with cash, ~~or~~ check **or credit card.**

~~6.~~**7.** The costs for Non-Employee AHA course participation ~~((Attachment A)~~ are ~~as follows~~**per AHA Class Price List.**~~:~~

~~BLS **provider (accelerated)**renewal- (not including BLS Provider Manual): $60**50**.00~~
~~**BLS provider full course - (not including BLS Provider Manual): $60.00**~~
~~a. **BLS skills - (not including BLS Provider Manual): $30.00**~~
~~b. ACLS and PALS renewal- (not including ACLS Provider Manual): $150.00~~
~~c. ACLS and PALS full course- (not including ACLS Provider Manual): $200.00~~
~~ACLS and PALS Skills sessions - $60~~

~~d.~~**8.** **AHA course – student manuals are required for all instructor-led events. Students must have a manual before, during and after the course.**

~~7.~~**9.** All costs will be refunded if course is canceled by ~~TCMC~~**TCHD** AHA TC

~~8. Cancellation by the student less than 2 working days prior to the class are subject to $50 administrative fee.~~

~~9.~~**10.** No shows will forfeit 100% of course fees

D. **FORM(S)**:

1. AHA Class Price List

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

1. American Heart Association Program Administration Manual

F. ~~**APPROVAL PROCESS**~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

AHA CLASS PRICE LIST

AHA CLASS PRICE LIST

As TCMC refunds all employees the cost of classes, 2 receipts are required – 1 for class and 1 for manual. Wellness Center employees receive a refund for BLS classes.

Name of Class	TCMC Employees **Refunded**	Staff MDs / Travelers	Staff MDs/ Travelers w/o Manual	Non-TCMC	Non-TCMC w/o Manual	Manuals Only
BLS Full Course – Blue Instruction Sheet	$25.00	$65.00	$50.00	$65.00	$50.00	$15.00
BLS Renewal – Tan Instruction Sheet	$25.00	$55.00	$40.00	$55.00	$40.00	$15.00
BLS Skills – Green Instruction Sheet	$25.00	$30.00	$30.00	$30.00		
BLS Skills Online Key		$18.00	$18.00	$18.00	$18.00	$18.00
ACLS Full Course – **Salmon** Instruction Sheet	$50.00	$200.00	$170.00	$225.00	$195.00	$30.00
ACLS Renewal Course – **Lavender** Instruction Sheet	$50.00	$120.00	$90.00	$150.00	$120.00	$30.00
Heartsaver AED Community Class – Red Instruction Sheet **($35.00 for class if they saw our ad in the newspaper)**				$65.00	$50.00	$15.00
NRP Renewal (Full Courses not offered)	$25.00	$100.00	$50.00	$100.00	$50.00	$50.00
PALS Full Course – Green Instruction Sheet	$50.00	$210.00	$175.00	$210.00	$175.00	$35.00
PALS Renewal – Green Instruction Sheet	$50.00	$135.00	$100.00	$135.00	$100.00	$35.00
ENPC Full Course – Pink Instruction Sheet	$50.00		$175.00		$175.00	Loaner
ENPC Renewal – Pink Instruction Sheet	$50.00		$100.00		$100.00	Loaner

*** Includes Manual**

All students signing up for ACLS/BLS classes **must** receive instruction sheet.

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: DESCRIPTION OF PROFESSIONAL EDUCATION DEPARTMENT

ISSUE DATE: 03/03
REVISION DATE(S): 07/05, 08/07, 04/10, 07/13

Department Approval:	**03/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**~~8/07; 4/10;~~ 7/13**

A. **POLICY:**

1. Scope of Services:
   a. The Education Department's scope of services provided to the organization consists of employee orientation, in-service education, continuing education, leadership and organizational development, project facilitation.
2. Operational Initiatives:
   a. The Education Department's operational initiatives are developed each year based on the organization's hospital wide operational plan.
   b. Quarterly, the operation plan is updated regarding status and accomplishments and reported by the Director of Education, ~~and~~ Clinical Informatic**s and Staffing**~~on~~ to the **Chief Nurse Executive** (CNE).
3. Physical Location:
   a. The Education Department offices are located on the lower level of the Pavilion below the main lobby area. The classrooms are adjacent to the offices. The Medical Staff Library is located on 1North.
   b. Storage of the Education Department's equipment and supplies are located in closets in the Assembly Rooms.
   c. Archived education files are indexed and stored off site if older than 1 year.
4. Hours of Operation:
   a. The hours of the Education Department are 7:30 am - 4:00 pm, Monday through Friday with the exception of organization-defined holiday**s** and by appointment.
   b. The Computer Labs in classroom 4 and classroom 8 can be accessed from 7:30 am - 4:00 pm.
      ~~c.~~**i.** The computer room in classroom 4 is available afterhours for completion of net learning modules by contacting **Tri-City Healthcare District (**TC**HD**~~MC~~**)** Security **at** 760-940-3367.

~~B. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

SUBJECT: IN-SERVICE EDUCATION

ISSUE DATE: 06/03
REVISION DATE(S): 08/07, 04/10, 07/13

Department Approval:	**03/17**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**07/13**

A. **POLICY:**

1. In-service education consists of those activities that assist personnel to fulfill assigned responsibilities specific to the performance standards of the work units. These activities are conducted internal to the facility and are directed at current standards.
2. The aim of inservice is to maintain competency (in relation to existing standards); create new competency (in relation to newly developed standards); respond to Performance Improvement findings (convert non-compliance to compliance); and introduce/review equipment.
3. Inservice for new products and equipment is initiated by the Clinical Value Analysis Committee whose membership includes an Education staff member.
4. The company vendor/representative contacts the Education Department to plan the most effective means of inservice training.
5. Leadership and Management may request inservice education to meet the individual practice needs of the work unit by contacting the education staff.

~~B. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~POLICY MANUAL~~

SUBJECT: ` MISSION AND VISION OF THE EDUCATION DEPARTMENT

ISSUE DATE: 03/03
REVISION DATE(S): 07/05, 08/07, 04/10, 03/12, 07/13

Department Approval:	**03/17**
Medical Executive Approval:	**n/a**
Professional Affairs Approval:	**09/17**
Board of Directors Approval:	**07/13**

A. **MISSION STATEMENT:**
1. To provide innovative educational experiences that advance the knowledge and skills of all Tri-City ~~Medical Center~~**Healthcare District** (TC**HD**~~MC~~) employees to promote excellence.

B. **VISION STATEMENT**
1. Create an environment to support evidence based practices by delivering education through progressive learning modalities.

C. **PROFESSIONAL EDUCATION DEPARTMENT:**
1. Mentors and supports lifelong learning
2. Promotes research and evidence-based practice
3. Integrates technological advances into practice
4. Facilitates Multi-disciplinary collaborations
5. Acts as resource to community
6. Serves as academic liaisons
7. Develops professional practice
8. Facilitates Interdisciplinary in-house/community education
9. Provides:
   a. Initial and ongoing assessment of staff skills, knowledge, behaviors and ability to provide patient care
   b. Continuing Education (CE) classes/programs
   c. Certification, orientation, computer training
   d. Annual competencies/Skills **Validation**~~Lab~~
   e. Proactive mandatory training/Netlearning
   f. CE/Tuition reimbursement
   g. Standards for basic competency/training
   h. Direct clinical research support staff through Information Specialist
   i. Supports disease specific care certification and ~~maintanence~~**maintenance** programs
10. Assists organization in meeting regulatory standards

~~D. **APPROVAL PROCESS**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 10/04

SUBJECT: Election Process of Member(s) at Large for the Medical Executive Committee

REVISION DATE(S): 04/08, 08/12

POLICY NUMBER: 8710 – 531

Department Approval:	**~~03/17~~07/17**
Medical Staff Committee Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/17~~08/17**
Professional Affairs Committee Approval:	**~~04/17~~09/17**
Board of Directors Approval:	**04/17**

A. **PURPOSE:**

1. To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

B. **PROCEDURE:**

1. All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
2. Interested Active Medical Staff members are required to complete a Conflict of Interest form before being added to the ballot.
3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
4. Voting will be by ballot.
5. A quorum of voting members is required to elect Members-at-Large.
6. Each voting member will be allotted two votes. A member may vote twice for any one candidate or vote once for any two candidates or withhold one or both votes.
7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
   a. If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
8. Vacant seat(s) after original appointment on the Medical Executive Committee shall remain vacant until the next June General Medical Staff Meeting.
9. Members-at-Large will serve a ~~one~~ **two** year term and no member shall serve more than two successive terms.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Admission to Inpatient Behavioral Health Unit**

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:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define appropriate methods for admitting a patient to an inpatient psychiatric unit.

B. **POLICY:**

1. When a patient is in need of inpatient treatment, the program staff and attending physician will arrange the admission.

C. **PROCEDURE:**

1. Who may perform/responsible: Clinical and Nursing Staff
   a. The treatment team, to include the Clinical Coordinator, Operations Manager and **Registered Nurse** (RN) whenever possible, meets to triage the patient and determine the need for inpatient admission.
   b. The clinical staff contacts the attending psychiatrist to inform him/her of the current situation and the staff's assessment of the patient and recommendations for admission.
   c. If the attending psychiatrist concurs that admission is necessary, s/he makes the recommendation as to whether a direct admission or **Emergency Department** (ED) admission must occur. If a direct admission is recommended, the attending psychiatrist, or designee contacts the on-call physician to make the recommendation and communicate information obtained in the clinical assessment. If an ED admission is recommended, the clinical staff contacts the psychiatric liaison to inform them regarding the potential admission. **Once the patient is medically cleared in the ED, they may be transferred to the crisis stabilization unit for evaluation and treatment or admitted to inpatient behavioral health unit.**
   d. If the patient refuses hospitalization, the attending program psychiatrist makes a determination as to whether a hold is necessary.
   e. The staff will be responsible for arranging for transport of the patient and obtaining consents from the patient/conservator, as needed. Depending on level of risk, a patient may need to be accompanied by staff on program van or be transported via ambulance.
   f. Staff will use the Situation, Background, Assessment, Recommendation (SBAR) process to conduct hand off communication with the intake coordinator, psychiatric liaison, shift Supervisor, MD, police department, or ambulance.
   g. The program staff will notify the patient's family or significant others of the transfer, in accordance with the patient's wishes. If appropriate, the patient's insurance reviewer is contacted and informed regarding the inpatient admission.
   h. Patient information/records will be sent at the time of transfer. These records will include diagnosis, pertinent financial/administrative information, current medical findings, current medications and a brief summary of the course of treatment. Program nurse and clinical staff will ensure accuracy of medication reconciliation and hand off communication.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Age Appropriate Care**

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:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	

A. **PURPOSE**

1. To provide guidelines to meet the age specific care needs of the patient and educate their caregiver **and/or** family.

B. **POLICY**

1. **OPBHS serves adults 18 and older. Efforts must be made to individualize the program to meet the specific needs of individuals and address age-related issues. Older adults may attend specialized groups to address issues related to their specific age group, such as aging and grief and loss issues. Likewise, young adults may be scheduled for groups with individuals of similar age to address issues that may arise for their age group, such as academic or job-related concerns.** All employees shall demonstrate the skills and knowledge required to provide care appropriate to the age of the patients served. Caregiver/family shall be involved in treatment to meet the age specific needs of the patient.

C. **PROCEDURE**

1. Who may perform/responsible: **Outpatient Behavioral Health Services** ~~BHOS~~ **(OPBHS)** staff
   a. Educational information including the principles of growth and development will be provided during orientation.
   b. The knowledge and skills necessary for providing age specific care will be reviewed annually.
   c. Knowledge, skill base, and ability to provide care appropriate to the age of the patient will be evaluated during orientation and at each annual performance review.
   d. Employees will include family/caregiver, as appropriate, in meeting age specific needs of the patient.
   e. Treatment approaches will be modified to meet the age specific physiological, psychological, educational and social needs of the patient.
   f. Medications will be prescribed in age appropriate medication dosages; therapeutic ranges can be obtained from the pharmacy and laboratory department as needed.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

DELETE: Department guideline, does not need to be a policy.

SUBJECT: Communications

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:	06/17
Pharmacy and Therapeutics Approval	n/a
Medical Executive Committee Approval:	07/17
Professional Affairs Committee Approval:	09/17
Board of Directors Approval:	

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

~~1. To define the policy regarding communication throughout the Program and with Tri-City **Healthcare District (TCHD)**Medical Center.~~

~~B.~~ ~~**POLICY**~~

~~1. All program staff have a responsibility to decrease barriers to communication and to make an effort to communicate effectively. Confidentiality of both verbal and written communication must be maintained at all times. Each staff member is expected to know the appropriate lines of reporting indicated in their job description and in specific policies and procedures. All staff act as role models in helping patients to communicate effectively.~~

~~C.~~ ~~**PROCEDURE**~~

~~Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) Staff~~

~~1. Meetings are held weekly to facilitate interdisciplinary communication. These include but are not limited to: staff meetings, clinical problem solving meetings and treatment team meetings.~~

~~2. A Patient Review meeting will take place each morning to review the previous day's events, review new admissions, issues related to patient care, and to discuss the schedule of the day.~~

~~3.a. The Operations Manager is also involved in **TCHD**Tri-City Medical Center meetings at the direction of the Director of Behavioral Health, which may include Leadership Meetings, Leadership College, Manager's meetings, and **Behavior Health Unit** (BHU) meetings. Relevant information gained at these meetings is shared with pro~~gram staff.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

Delete: Department guideline, does not need to be a policy.

SUBJECT: **Solicitation of Patients / Referrals to Self**

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:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	

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

~~1. To specify parameters with respect to the solicitation of patients or referrals to self.~~

~~B.~~ ~~**POLICY**~~

~~1. Who may perform/responsible: **Outpatient Behavioral Health Services** (OPBHS) Clinical Staff~~

~~2. Tri-City **Healthcare District (TCHD)**Medical Center employees and contracted employees will not refer patients, directly or indirectly, to their private practices.~~

~~3. Tri-City Medical Center**TCHD** employees and contracted employees will not, directly or indirectly, approach, solicit or suggest to any patient (or patient's representative) that the patient should or must see such employee on any basis outside the program(s) for additional care or therapy, with the exception of those patients who were seen in the therapist's private practice prior to the patient being admitted to the program. In such a case, referrals back to the therapist's private practice is **are** acceptable, if deemed clinically appropriate.~~

~~4. If additional treatment is needed, as determined by the treatment team a list of at least three qualified therapists will be given to the patient for the patient's selection.~~

~~5.~~**1.** ~~An exception to the above is when a patient expresses an interest in continuing to see the program psychiatrist after discharge from program. In that case, it would be acceptable for the patient to continue to be treated by the program psychiatrist in their private practice.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Substance Abuse**

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:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval	**09/17**
Board of Directors Approval:	

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

~~1. To identify steps to address use of non-prescribed drugs or alcohol in Outpatient Behavioral Health Services.~~

~~B.~~**A. POLICY:**

1. Patients with ~~secondary~~ **comorbid** substance abuse problems or dual diagnosis may be treated in ~~the Program~~**OPBHS** if they agree to ~~abide by~~**adhere to** ~~Program~~**OPBHS** ~~rules~~ **guidelines** and if they agree to accept treatment for their substance **use**~~abuse~~ problem.
2. Patients are not permitted to attend ~~the Program~~**OPBHS** under the influence of alcohol, **marijuana** or ~~street~~ **illicit** drugs or to bring those substances to ~~the Program~~**OPBHS**. Substance abuse is also defined as "~~taking excessive amounts of~~**misuse of** prescribed medications".
   a. **An individual under influence can include individuals that use alcohol, marijuana, illicit drugs or misuse prescribed medications the day they are in the program or the night before.**
   b. **Behaviors that may indicate an individual is under the influence include, someone behaving differently than usual, erratic, with an altered state of consciousness, unpredictable behavior, agitation, excessive sedation, slurred speech, dilated eyes, impaired gait, etc.**
3. If the patient's substance ~~abuse~~ **use** problem becomes so severe that it endangers the patient's safety, interferes with psychiatric treatment, or prevents the patient from benefiting from treatment, a referral to a **higher level of care or a** substance abuse program may be made.

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

1. Who may perform/responsible: OPBHS Clinical and Nursing Staff

~~1.~~**2.** If substance abuse is detected by ~~program~~**OPBHS** staff during ~~program~~**OPBHS** time, the patient will be dismissed for the day. The patient's physician/**Allied Health Professional (AHP)** will be immediately notified.

3. If the patient may be medically endangered by his substance abuse, the physician/**AHP** will be notified before the patient is dismissed in order to determine the best approach to take and to assess the need for immediate medical treatment.

~~2.~~**4. With collaboration with physicians/Allied Health Professionals, OPBHS staff will determine a safe plan to transport the individual home and to ensure that the individual does not drive under the influence.**

~~3.~~**5.** At the time of dismissal, the patient will be reminded that he/she must meet with the Therapist or treatment team before he/she may continue in the ~~Program~~**OPBHS**. If the patient does not call back within 24 hours, the Therapist will contact the patient to schedule the meeting. The meeting will include consideration of the patient's possible need for substance abuse treatment,

within or independent of the ~~Program~~**OPBHS**.

~~4.~~**6.** If the individual continues in treatment, a contract for continuing participation in the Dual Diagnosis component of the program ~~will~~ **may** be developed. The contract may address various issues, such as substance abuse abstinence, participation in dual diagnosis groups, 12-step meeting attendance, avoidance of high risk places or things, etc.

~~5.~~**7.** Repeated violations of ~~Program~~**OPBHS** rules concerning substance abuse may result in the patient's discharge from the ~~Program~~**OPBHS**.

~~6.~~**8.** The incident is documented in the patient's record along with a description of the action taken.

~~7.~~**9.** Patients are referred to a higher level of care or substance use treatment if they are determined to meet one or more exclusionary criteria, which include:

a. Lack of interest in being clean or sober and refusal to reduce substance use
b. Daily excessive drinking or signs of withdrawal and increased tolerance
c. More than one occasion of coming to ~~program~~**OPBHS** under the influence
d. Multiple relapses and refusal to take steps to improve chance of success
e. Inability to reduce use
f. Multiple episode**s** of dishonesty regarding use
g. High risk of suicide, violence, medical issues, homicide, or severe exacerbation of symptoms associated with use.
h. Extent of prescription use leads to high risk of self harm
i. Refusal to communicate with other prescribing **physicians/AHPs**~~MDs~~, or **primary care physician (**PCP**)**, or family/caregivers combined with severe risk of self harm
j. Continued use of multiple pharmacies, **Emergency Departments (**EDs**)**, and physicians/**AHPs** and refusal to change this high risk behavior
k. Poses a risk to milieu by influencing other patient to use substances
l. The team, including the physician, determines that patient has a current primary issue with substance use and can benefit from substance use treatment.

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: **Suicide 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:	**06/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the course of action necessary when a patient expresses suicidal ideation.

B. **POLICY:**

1. Acutely suicidal patients are not appropriate for Outpatient Behavioral Health Services **(OPBHS)** and need to be evaluated for inpatient treatment. If a patient is admitted for inpatient care, ~~program~~**OPBHS** staff will follow the patient's progress and assist in assessing the patient's readiness to return to ~~the Program~~**OPBHS**. Patients reporting suicidal ideation will be assessed for level of risk and appropriate interventions will be conducted accordingly.

C. **PROCEDURE:**

1. ~~—~~Who may perform/responsible: OPBHS Clinical Staff.

~~1.~~**2.** All new patients will undergo a**n evidence-based** ~~suicide~~ **suicide risk** assessment**, such as the Columbia-Suicide Severity Rating Scale (C-SSRS). The assessment is** ~~at~~**completed at** intake ~~that is completed~~ by the ~~admitting RN~~**Clinical staff**.

~~2.~~**3.** If a patient is assessed to be at moderate or high risk for suicide, then the ~~RN~~ **staff** notifies the physician**/Allied Health Professional (AHP)** ~~and therapist~~ in order to evaluate appropriate level of care needed for the patient.

~~3.~~**4.** If ~~MD~~ **physician/AHP** determines that the patient can safely remain in ~~program~~**OPBHS**, ~~RN will~~**staff will** provide the patient with information on how to access emergency crisis services **and will develop a safety plan**.

~~4.~~**5.** The therapist will establish a treatment goal specifically addressing safety for those patients that score moderate to high on the suicide assessment.

~~5.~~**6.** If, during the course of treatment, the ~~program~~**OPBHS** staff member becomes aware of a patient's suicidal intentions or actions, he/she becomes responsible for initiating a course of action. That person, or designee, must take necessary precautions to ensure patient's safety.

7. Assessment will be immediately initiated to determine the risk of the suicidal intent or action.

~~6.~~**a.** ~~(~~Some of the factors to consider are: whether the patient has a specific plan to make an attempt, whether the patient is now experiencing circumstances that would enhance the likelihood of the attempt, etc.~~).~~

~~7.~~**8.** The staff member who discovers the situation will ~~initiate a plan of action after~~ inform~~ing~~ the physician, Clinical Coordinator, and the Operations Manager.

~~8.~~**9.** An action plan is initiated based on the assessment of acuity.

a. If a suicide attempt has already been made, the patient is to be transferred immediately to Tri-City **Healthcare District's (TCHD)**~~Medical Center~~ emergency room by ambulance. A staff member will be designated to notify the patient's physician**/AHP** and family member or significant other.

b. If a suicide attempt has not been made, but the threat is considered to be imminent, the patient's physician**/AHP** is to be contacted immediately to give direction concerning the patient's disposition. If the patient's attending physician**/AHP** is not available, the Medical Director will be contacted.

c. Patients that are identified at risk will be closely monitored until they are transported safely for inpatient treatment.

d. Patient**s** that are on close watch will be asked to voluntary give staff their belongings in case they possess any contraband items and to protect their safety.

~~d.~~**e.** If the threat of suicide is determined not to be imminent, the ~~staff member will notify other staff and the Operations Manager~~**treatment team will be notified** to heighten awareness to possible future suicidal ~~intent~~ **risk** and also to plan further treatment interventions. A written **safety plan will be developed by the patient and the therapist to help identify warning signs, coping strategies, and emergency resources.** ~~contract to notify staff before acting on any impulse may be signed by both patient and staff and placed in the chart. A written contract is to be used as a therapeutic intervention rather than an effort to protect the program.~~**written safety plan will be completed to help patients identify resources and remain safe.** If appropriate, the patient's family/support system/Board and Care Manager should be contacted to monitor for safety.

~~9.~~ Document in the patient's ~~chart~~ **medical record** the patient's statements and actions, the assessment process, the disposition of the patient and staff interventions. ~~If the patient is to remain in program~~**OPBHS**~~, the therapist may initiate a written contract~~ **safety plan** ~~to include emergency crisis numbers and address steps that can be taken if the patient felt unsafe.~~

10. The patient's Therapist will discuss all verbalizations of suicidal ideation with the patient's attending psychiatrist and the treatment team in order to develop appropriate treatment interventions.

11. ~~the~~**The** ~~Program~~**OPBHS** staff will contact the inpatient treatment team, should the patient be hospitalized, to insure continuity of care and to conduct hand-off communication.

D. RELATED ~~RESOURCES~~DOCUMENT(S):

1. **Outpatient Behavioral Health: Psychiatric Emergencies**

E. REFERENCES:

1. **The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence (2017)**
2. **The Joint Commission Source Newsletter (2016)**
~~12.~~3. **The Joint Commission National Patient Safety Goals (2017)**

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~– OCEANSIDE POLICY MANUAL~~

ISSUE DATE: **03~~2~~/13** **SUBJECT:** **ADVERSE REACTION (MEDICATION EVENT)**

REVISION DATE: **03/13**

Department Approval:	**06/16**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
Division of Oncology Approval:	**03/17**
Pharmacy and Therapeutics Approval:	**07/17**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. Patient medication events including adverse reactions must be reported appropriately and acted upon in a timely manner. This policy defines the procedure to be followed by the ~~OP~~**Outpatient** Infusion Center **(Center)** when a medication error/reaction/event occurs.

B. **POLICY:**

1. The Center will adhere to the hospitals pharmacy policy(s) related to medication events/adverse reaction and utilize appropriate hospital reporting forms.
2. All adverse drug reactions/medication events will be reported immediately and will include notification of the practitioner who ordered the drug, as well as the patient/family.
3. Appropriate documentation will be recorded in the medical record.
4. The pharmacy will report serious adverse drug reactions to the Food and Drug Administration as required.

C. **PROCEDURE:**

1. The nurse shall:
   - **a.** Notify the attending **and/or onsite** physician of the medication event/reaction
   - ~~a.~~**b. If the interventions ordered by the attending and/or onsite provider fails when patient is having anaphylactic symptoms, the nurse or designee will call 911 for emergency services.**
   - ~~b.~~**c.** Notify the patient/family of the incident.
   - ~~c.~~**d.** Complete the appropriate form to the pharmacy immediately.
   - **e.** Document the event/reaction, the orders received, and the effect/condition of the patient in the patient's medical record.

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

~~d.~~**1. Administrative Policy: Incident Report—Quality Review Report (QRR) RL Solutions 396**

Tri-City Medical Center	Distribution: Outpatient Infusion Center

~~PROCEDURE:~~	~~CENTRAL VENOUS ACCESS DEVICES, ADULTS~~
~~Purpose:~~	~~To outline the nursing responsibility in:~~ ~~A. Insertion~~ ~~B. Assessment~~ ~~C. Maintenance~~ ~~D. Documentation~~ ~~E. Flushing~~ ~~F. Blood draws~~ ~~G. Dressing changes~~ ~~H. Accessing or de-accessing implantable venous access ports~~ ~~I.~~**A.** ~~Removal of non-tunneled central lines (Peripherally Inserted Central Venous Catheter (PICCs), short term multi lumen catheters, vas catheters)~~
~~Supportive Data:~~	~~See Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10).~~
~~Equipment:~~	~~Refer to Appendix A for details.~~

DELETE – follows Patient Care Services Procedure: Central Venous Access Devices, Adults

~~ONLY REGISTERED NURSES (RNs) MAY ACCESS CENTRAL LINES~~

~~A. INSERTION~~

1. ~~Assemble supplies (See Attachment B for procedure lists)~~
2. ~~Propose optimal catheter site to physician, with Subclavian Vein as the preferred site for non-tunneled catheters.~~
3. ~~Ensure the physician has performed chlorhexidine skin antisepsis~~
4. ~~Provide maximal barrier precautions for inserting physician and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves and full body sterile drape)~~
5. ~~Ensure "time out" is performed per Patient Care Services (PCS) Universal Protocol procedure~~
6. ~~The Registered Nurse (RN)/healthcare provider (HCP) shall ensure sterility of the field is maintained throughout the procedure.~~
7. ~~Verify an X-ray is ordered and completed after placement on newly inserted central venous catheters.~~
8. ~~Ensure Central Line Insertion Procedural Checklist is completed (see Attachment A)~~

~~B. ASSESSMENT~~

1. ~~Monitor intravenous sites every 2 hours and PRN. Document each shift on the Assessment Ongoing PowerForm Central IV section.~~
2. ~~Central venous catheters are assessed daily to determine continued need and are removed when no longer needed.~~
   a. ~~The primary RN is responsible for ensuring the unit secretary places a "Physician Daily Assessment of Central Line Necessity "sticker on a Physician Order sheet daily.~~
   b. ~~When a unit secretary is not available, the Shift Supervisor shall ensure the "Physician Daily Assessment of Central Line Necessity" sticker is placed on a Physician Order sheet.~~
   c. ~~Does not apply to long term catheters (Groshong, Tunneled Catheter, Medi-Port, and Vas Cath)~~

~~C. MAINTENANCE~~

1. ~~Use all new tubing after new PICC/central line placement.~~
2. ~~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.~~
3. ~~Change tubing and any attached devices (e.g. extension tubing, neutral displacement connector) every 4 days.~~

Department Review	Division of Oncology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/13, 01/17	**03/17**	**07/17**	03/13, **08/17**	03/13, **09/17**	03/13

4. Use an infusion pump for all infusions.
   a. DO NOT ALLOW INFUSIONS TO RUN DRY.
5. Clamp tubing distally if air enters infusion tubing; aspirate fluid and air with a syringe from Y port. Never purge infusion line into patient.
6. Maintain keep open rates at 20 mL per hour.
7. Continuous infusions may be connected hub to hub. Microclave device is only required for intermittent access.
8. SwabCap – Unused central line ports will have a SwabCap placed on the end of the neutral displacement connector (Microclave).
   a. Apply the SwabCap to the end of the neutral displacement connector (Microclave) by opening the packaging of the SwabCap and twist into the end of the neutral displacement connector (Microclave).
   b. To access a central line that has a SwabCap, remove the SwabCap from the neutral displacement connector (Microclave) and access central line port. No initial cleaning of the neutral displacement connector (Microclave) is needed after SwabCap is removed.
   c. Do not reuse the SwabCap, a new one should be used each time it is removed, every 8 hours with routine IV flushing and PRN.
9. Outpatient Infusion Center may replace Chlorhexadine with Alchohol/Betadine skin prep for dressing changes and Implanted Port access.

D. **DOCUMENTATION**
1. Document and complete all sections of the Assessment Ongoing PowerForm in the Central IV section.
2. Document flushing on the Medication Administration Record (MAR)
3. Record teaching on the Patient Education PowerForm.

E. **FLUSHING**
1. Obtain a physician's order prior to accessing any central venous catheter if the patient is admitted with a pre-existing line and a diagnosis of sepsis or suspicion of line sepsis.
2. Always flush and check patency with a 10 mL size syringe due to the greater amount of pressure per square inch exerted with smaller syringes. Once patency has been established with a 10 mL normal saline flush, the use of a smaller syringe to administer medications is acceptable.
3. Flush with minimum of 10 mL normal saline:
   a. Before and after medication administration,
   b. After IV fluids or TPN discontinued
   c. For maintenance
   d. Before and after blood draws
   e. After blood backs up in the tubing
4. Flush unused ports with each use and as indicated in Catheter Specific Flushes table (see Attachment C)
5. Heparin flushes require a physicians order. Refer to Central Venous Access Device Flushes Pre-Printed Order.
6. Flush ports with heparin for patients discharged with a central line to ensure patency for home care or other facility use (see Attachment C).
7. **PROCEDURE:**
   a. Identify type of catheter
   b. Check for Chloraprep (2% chlorhexidine gluconate/70% isopropyl alcohol), Heparin, Betadine, and alcohol allergies.
   c. Assemble supplies (See Attachment B for procedure lists)
   d. Explain procedure to patient.
   e. Perform hand hygiene and don clean non-sterile gloves.
   f. Remove SwabCap from the neutral displacement connector (Microclave) if used.
      i. If a SwabCap is not present on injection port, cleanse neutral displacement connector thoroughly using 3 alcohol wipes or chlorhexidine swab.

g. Briskly flush catheter with normal saline and follow with catheter specific flush (See Attachment C).
h. Always wipe the neutral displacement connector with an alcohol wipe immediately before and after each syringe insertion to remove bacteria and prevent blood from accumulating.
i. Repeat flush procedure for each catheter lumen.

F. BLOOD SPECIMEN COLLECTION FROM VENOUS ACCESS DEVICES

1. Peripheral blood is preferable for coagulation studies. A physician's order is required if a line will be used to obtain blood for coagulation studies when the line has heparin infusing or if heparin was used as a routine flush.
2. Maintain a closed system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood cultures.
   a. If the neutral displacement connector is removed for a blood draw, aseptic technique (with sterile gloves, mask and sterile field) must be used.
3. On Acute Care Services (ACS) and Telemetry, a phlebotomist shall place plastic bags labeled with the patient's identifiers in the "Pending Labs" box on each unit prior to the morning blood draws.
4. Nursing shall review their orders for morning draws and complete the blood draws.
5. Once the blood draws are completed, nursing shall return the labeled specimen collection tubes to the patient's plastic specimen bag and place the specimen bag in the "Lab Test Pick-Up" box for phlebotomy to pick up.
6. Phlebotomy shall contact nursing on ACS and Telemetry if additional blood draws are required after the morning draw.
   a. Nursing may complete the blood draws without a phlebotomist being present.
   b. A phlebotomist must be present for blood cultures and blood bank draws.
7. **PROCEDURE:**
   a. Remove patient identified plastic bag with specimen collection supplies from the Pending Lab box on Acute Care Services and Telemetry.
      i. Do not take plastic specimen bag into isolation rooms.
   b. Verify patient by ensuring two patient identifiers match the specimen collection labels
   c. Perform hand hygiene
   d. Assemble supplies (See Attachment B for procedure lists).
   e. Explain procedure to patient.
   f. Position patient, supine is the preferred position.
   g. Turn off any continuous infusions and disconnect as needed.
   h. Ensure all clamps are open.
   i. Perform hand hygiene and don clean non-sterile gloves.
   j. Remove SwabCap from the neutral displacement connector (Microclave) if used.
      i. If a SwabCap is not present on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.
   k. Use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry, do not fan or blow on port to speed drying.
   l. Flush with 10 mL normal saline; wait 2 minutes.
   m. Draw off and discard 5 mL of blood. If drawing specimens for blood cultures or coagulation studies are to be obtained or the line has TPN infusing draw off and discard 10 mL of blood.
      i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect discard blood.

ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Reconnect tubing or replace with a new neutral displacement connector.

n. Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating.
   i. Allow to dry, do not fan or blow on site to speed drying.

o. **For Direct Transfer Method**
   i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.
   ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.
      1) On ACS and Telemetry, insert blood specimen collection tube in the appropriate numbered draw order i.e. 1, 2, etc).
   iii. Remove and insert new vacuum tubes as needed.

p. **For Indirect Transfer Method**
   i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.
      1) A safety transfer device must be used to fill the vacuum tube from a syringe.

q. Remove device or syringe and wipe away blood residual.

r. Flush as indicated in Catheter Specific Flushes table (see Attachment C) and reconnect to infusions.

s. Re-clamp lines as appropriate.

t. Remove gloves and perform hand hygiene

u. Don clean gloves

v. Document your Cerner logon, date and time of lab draw on the specimen label(s)

w. Place label(s) on specimen collection tube(s) at patient's bedside.
   i. On ACS and telemetry, ensure the color written on the patient label(s) matches the color of the specimen collection tube(s).

x. Place labeled specimen collection tube(s) in the patient's specimen collection bag on ACS and Telemetry units.

y. Place specimen collection bag in the "Lab Test Pick Up" box.
   i. A phlebotomist will transport the specimen(s) to the lab.

G. DRESSING CHANGES

1. Transparent dressings with Biopatch disk shall be changed every 7 days.
2. Gauze dressings (including transparent dressings with gauze underneath) shall be changed every two days.
3. Dressings shall be changed as needed if they become loose, soiled, or moist.
4. Access needles for implanted ports shall be changed every 7 days.
5. Central neutral displacement connector (Microclave) shall be changed every 4 days.
6. For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion.
7. **PROCEDURE:**
   a. Obtain central line dressing change kit from supply Pyxis.
   b. Explain procedure to patient.
   c. Use Standard Precautions during dressing change (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions).*
   d. Avoid talking over site and have the patient turn away from the site to prevent contamination.
   e. Perform hand hygiene, don clean non-sterile gloves, and remove the dressing and discard.
   f. Inspect the site for:
      i. Signs of infection i.e. redness, or purulent drainage.
      ii. Ensure the securement device and/or sutures are intact
      iii. Ensure the catheter is not kinked, leaking, or otherwise compromised.

g. Remove non-sterile gloves and perform hand hygiene.
h. Open sterile supplies and don sterile gloves and sterile mask.
i. Perform hand hygiene and don sterile gloves
j. Apply Chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds.
k. Cleanse catheter tubing from exit site to distal end.
l. Allow antiseptic to air dry (do not blow on or fan site) before redressing.
m. Replace securement device if needed per manufacturer's guidelines.
n. Position tubing in a loop away from the insertion site.
o. **Transparent Dressing with Biopatch**
    i. Place Biopatch disk around catheter with blue side up and white foam side next to skin at exit site.
    ii. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.
    iii. Center transparent dressing over exit site and the Biopatch disk.
    iv. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.
p. **Implanted Venous Access Devices/Vita Ports/Medi-Ports**
    i. Place folded 2x2 gauze under wings only if wings are not flush with skin.
    ii. Gauze should be placed under wings in such a way as to allow visibility of insertion point.
    iii. Secure wings with sterile steri-strips.
    iv. Use transparent dressing to cover site.
    v. Write date of dressing change and your initials legibly with a permanent black marker directly on the dressing, allowing time for the ink to dry.

H. ACCESSING OR DE-ACCESSING IMPLANTED VENOUS PORTS

1. ACCESSING PROCEDURE:

a. Obtain physician's order to use implanted device.
b. Assemble supplies (See Attachment B for procedure lists) and use safety needles.
c. Explain procedure to patient.
d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.
e. Use Standard Precautions while accessing implanted venous ports (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions)*
f. Avoid talking over site and have the patient turn away from the site to prevent contamination.
g. Assemble equipment on sterile field.
h. Perform hand hygiene and don sterile gloves and using aseptic technique waste 5mL normal saline from 10mL pre-filled syringe then prime the non-coring needle and extension tubing (with neutral displacement connector attached). Leave the syringe attached.
i. Using Chloraprep, cleanse area over implanted port thoroughly with a gentle back-and-forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
    i. Locate port septum by palpation and triangulate port between the thumb and first two fingers of non-dominant hand.
    ii. Aim for the center of the port and insert the needle, perpendicular to port septum. Advance needle through skin and septum until it reaches the bottom of the reservoir.
j. Do not begin injection or infusion until proper needle placement is confirmed by aspirating blood. Confirm placement by:
    i. Aspirating 5 mL of blood using the 10 mL syringe attached to the extension tubing.
    ii. Waste 5mL aspirant.
    iii. Flush with 10mL normal saline.

iv. Apply dressing per "Dressing Change" (section F) procedure.
1) Date and initial dressing.

k. After procedure, flush with 10 mL normal saline and follow with catheter specific flush (see Attachment C) or connect to IV infusion as ordered.
i. If implanted port must be accessed multiple times for PRN or intermittent medication regime, obtain a physician's order for KVO solution.
ii. If KVO order is unobtainable and port must be accessed multiple times perform the following:
1) Withdraw 5 mL from accessed implanted port and discard (removes heparin)
2) Flush port with 10 mL of normal saline after heparin has been removed
3) Administer medication or IV via port
a) When port is no longer needed, flush with 10 mL of normal saline and heparinize port per flush table. (Attachment C)

l. Access needle for implanted ports shall be changed every 7 days.

2. **DE-ACCESSING PROCEDURE:**
a. Check for blood return prior to flushing port with a 10 mL pre-filled normal saline syringe.
b. Flush port with 10 mL normal saline
c. ALWAYS flush port with specific flush prior to de-accessing (See Attachment C).
d. Perform hand hygiene and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable.
e. Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage.
f. Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol.
g. To remove the safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased.
h. Discard needle in a sharps container.
i. Apply small band-aid.

I. REMOVAL OF NON-TUNNELED CENTRAL LINES (PICCs, Multi-Lumen, Vas Cath)

1. **PROCEDURE:**
a. Verify physician order to discontinue line.
b. Assemble supplies (See Attachment B for procedure lists)
c. Explain procedure to patient.
d. Place absorbent pad under catheter site.
e. Have patient lay flat or have head of bed no more than 30 degrees if possible.
f. Use Standard Precautions for removal of non-tunneled central lines (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions)*
g. Open the suture removal kit.
h. Perform hand hygiene and don clean non-sterile gloves to remove the dressing and discard.
i. Check site for signs of infection.
i. If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's order.
j. Remove securement device if applicable.
k. Cleanse exit site with Chloraprep with a back and forth motion for 30 seconds. Use Betadine if patient is allergic to Chloraprep or alcohol.
l. Carefully remove sutures by grasping one-at-a-time with forceps held by the non-dominant hand. Use the dominant hand to clip suture at a spot close the skin. Take care so as not to cut catheter or patient's skin.
m. Instruct patient to perform Valsalva maneuver during removal. If patient is unable to hold his/her breath and bear down, place the bed as flat as possible.
i. For PICCs, have patient keep her/his arm straight.

n. With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull the catheter to remove. As catheter is coming out, place 4x4 over insertion site.
o. Once removed, apply pressure with sterile 4x4 gauze to the insertion site for 5-10 minutes or until bleeding has ceased.
p. Apply new sterile folded 4x4, secure with large transparent dressing, and instruct patient to leave dressing on for 24 hours.
q. Instruct patient to report shortness of breath, hematoma, or bleeding.

J. **ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH**

1. These Catheters Contain Large Doses of Heparin. HEPARIN MUST BE ASPIRATED BEFORE USE.
2. **ACCESSING PROCEDURE:**
   a. Obtain a physician's order to access ONLY the venous port (blue port) r.
   b. Explain procedure to patient.
   c. Assemble supplies (See Attachment B for procedure lists)
   d. Use Standard Precautions while accessing the double lumen subclavian/internal jugular vascath/permcath (Refer to Infection Control Policy IC.5 *Standard and Transmission Based Precautions)*
   e. Expose limb with the vas cath/permacath to prevent the patient from contaminating the ports with linens or gown.
   f. Place absorbent pad under the limb to protect clothing and linen. Place sterile drape over Chux and have patient center limb on the drape.
   g. Perform hand hygiene and don sterile gloves.
   h. Ensure venous line is clamped before accessing.
   i. Saturate venous port thoroughly with Betadine and let stand for 5 minutes.
   j. Attach 10 mL syringe using aseptic technique
   k. Unclamp and aspirate 5 mL (7 mL if drawing a PT or PTT).
   l. Clamp line and discard syringe.
   m. Attach 10 mL syringe containing 10 mL of normal saline.
   n. Unclamp venous port and instill 10 mL of normal saline.
   o. Clamp venous port and remove syringe.
      i. Venous line may now be accessed for IV fluids/IV medication administration.
         1) If a blood draw is needed, follow item E of this procedure "Blood Specimen Collection from Venous Access Devices."
3. **DE-ACCESSING:**
   a. Flush venous port with 10 mL of normal saline after medication administration, after discontinuing IV fluids or after completion of blood draw.
   b. Heparinize Port (see Attachment C for dosage) and label with a "**Caution – High Dose Heparin"** sticker.

K. **FORMS**

1. Central Line Insertion Procedural Checklist
2. Central Line Supply List
3. Central Line Catheter Specific Flushes

L. **REFERENCES:**

1. San Diego Dialysis Center. (2204). Fmc hemodialysis procedure manual.
2. Infusion Nursing Standards of Practice. (2006)
3. Bard. (n.d.) Long term polyurethane hemodialysis/apheresis catheters Bard nursing procedure manual

Attachment A

Central Line Insertion Procedural Checklist

Rationale: Evaluation of procedural practice during Central Venous Catheter insertion. Achieve compliance with CDPH mandates for public reporting under SB739.

Date: _____

Patient Name: _____ **MRN:** _____ **Room Number:** _____

Procedure performed in: ☐ Interventional Radiology ☐ Other - Specify _____ (i.e. NICU ICU, ED, OR)

Occupation of inserter: ☐ Interventional Physician ☐ Interventional PA ☐ Other Medical Staff
☐ Other specify _____

Checklist completed by: ☐ Inserter ☐ Observer

Indication for Central Line:
☐ New access ☐ Replace malfunctioning line ☐ Suspect central line infection

Line changed over guide wire? ☐ Yes ☐ No

Hand hygiene performed prior to central line insertion: ☐ Yes ☐ No
(Appropriate hand hygiene includes the use of alcohol-based hand rub or 15-20 second soap water hand wash.)

Maximal Sterile Barriers used:
- Mask/Eye Shield: ☐ Yes ☐ No
- Sterile Gown: ☐ Yes ☐ No
- Large sterile drape (full body): ☐ Yes ☐ No
- Sterile Gloves: ☐ Yes ☐ No
- Cap: ☐ Yes ☐ No
- Did assisting nurse follow the same precautions? ☐ Yes ☐ No

Skin Preparation:
- Chlorhexidine gluconate (Chloraprep) ☐ Yes ☐ No
- Betadine ☐ Yes ☐ No
- Alcohol ☐ Yes ☐ No

Was skin agent completely dry at the time of first puncture? ☐ Yes ☐ No
*30 seconds for dry site
**2 minutes for moist site (especially femoral)

Insertion Site: ☐ PICC Upper extremity ☐ PICC Lower extremity ☐ Jugular
☐ Subclavian ☐ Femoral ☐ Other: _____

Type of catheter: ☐ PICC ☐ Non-tunneled catheter (other than dialysis)
☐ Tunneled Catheter ☐ Dialysis Catheter tunneled
☐ Dialysis Catheter non-tunneled ☐ Vascular Catheter tunneled
☐ Other: _____

Number of lumens _____

Was antiseptic ointment applied to the site? ☐ Yes ☐ No ☐ N/A
Was biopatch placed on insertion site, dressing labeled with date and time? ☐ Yes ☐ No ☐ N/A

Please return completed form to the Manager and forward to Infection Prevention and Control. **Thank you**

~~Attachment A~~

~~Central Line Insertion Procedural Checklist~~

~~**Rationale**: Evaluation of procedural practice during Central Venous Catheter insertion in the Intensive Care Unit.~~

SAMPLE

~~**Please return completed form to Clinical Manager.**~~
~~Thank you~~

Central Line Supply lists	Attachment B
Insertion	1. Central Line insertion kit 2. Caps for assistant and physician 3. Full face shield for assistant 4. Mask with face shield for physician 5. Sterile gloves for assistant and physician 6. Sterile gown for physician 7. Full body sterile drape 8. Alcohol gel hand hygiene solution
Flushes	1. Non-sterile gloves. Mask if flushing a vas cath/permacath. 2. Alcohol wipes 3. Sterile field (may use 4x4 sterile gauze) 4. Sterile flush solution (see Catheter Specific Flushes - Attachment C) 5. 10mL Sterile normal saline filled syringe 6. 1 neutral displacement connector for each lumen.
Blood Specimen Collection	1. Non-sterile gloves (sterile gloves and sterile field for blood cultures) 2. Mask and goggles or full face shield 3. Alcohol wipes (3) or chlorhexidine swab 4. One 10 mL luer lock syringe for blood waste 5. Luer lock syringe(s) for blood specimen collection as provided by phlebotomist or safety vacutainer blood collection device 6. Patient lab identification labels 7. Vacuum blood specimen tubes as provided by phlebotomist 8. Plastic bag with patient labels for ACS and Telemetry morning blood draws 9. 10mL luer lock syringe with 10ml sterile normal saline 10. Sterile flush solution as appropriate (see Catheter Specific Flushes - Attachment C) 11. Neutral displacement connector
Dressing Changes	Obtain central line dressing change kit from supply Pyxis.
Accessing or De-accessing Implantable Venous Ports	1. Non-sterile gloves 2. Mask and goggles or full face shield 3. Alcohol wipes 4. Sterile drape 5. Sterile gloves 6. Use only safety, non-coring needles to access implanted port, 7. Extension tubing per patient needs for length and gauge. 8. Neutral displacement connector attached to extension tubing 9. 10mL syringe filled with sterile normal saline a. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol. 10. Transparent dressing or 2x2 split sterile gauze and 4x4 or 2x2 sterile gauze. 11. Steri-strips (optional) 12. Tape 13. Flush solution as appropriate (See Catheter Specific Flushes - Attachment C)
Removal Of Non-Tunneled Central Lines (PICCs, Multi-Lumen, Vas Cath)	1. Non-sterile gloves/ Mask and goggles or full face shield 2. Suture Removal Kit 3. Barrier-proof absorbent pad 4. Regular plastic bag for packaging and dressing disposal 5. 2x2 gauze, two 4x4 gauze 6. Large transparent dressing 7. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol

CENTRAL LINE CATHETER SPECIFIC FLUSHES — Attachment C

TYPE	FLUSH SOLUTION	FREQUENCY	COMMENTS
Central Lines	Normal saline10mL	Q 8 hrs	1. Use proximal port as 1st choice for drawing blood, routine IV administration, and medication. 2. Use Medial port for TPN and may use for medications only if TPN not being given and not anticipated. 3. Distal port as alternative site for blood draw, administration of viscous fluids (i.e. blood products, colloids, albumin), CVP monitoring, and continuous fluid administration.
PICC	Normal saline 10mL	Q 8 hrs	
Patients going home with Central line or PICC	Heparin 20 units per lumen • 2mL of Heparin (10units /mL)	Q 12 hrs	Home Care: Q 24 hrs
Groshong	Normal saline 10mL	Once a week	
Implanted Port (VAD)			
Groshong	Normal saline 10mL	Once a month	
Vita-Port	Heparin 300 units • 300 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Medi-Port	Heparin 500 units • 500 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Vas Cath	Heparin Concentration 1000 units/mL • Check number on venous port • Instill that exact number in mL of heparin using the 1000 units/mL concentration (i.e. 1.6=1.6mL, 1.7=1.7mL, 1.8=1.8mL).	Once a week If not being accessed for dialysis	1. Only the Venous (blue port) port may be accessed and a Physician's order is required before use. 2. Venous port must be clamped before syringes are connected or withdrawn. 3. Accessing – MUST ASPIRATE HEPARIN BEFORE USE. Using a 10mL syringe, remove 5mL of blood from the venous port and discard (7mL if drawing PT and/or PTT). Then port can be accessed. 4. De-accessing – Each Vas Cath/Permacath have a number located on the venous port that is the number of mL of heparin to be instilled when heparinizing the port (i.e. 1.6,1.7, 1.8)

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~- OCEANSIDE POLICY MANUAL~~

ISSUE DATE:	**03~~2~~/13**	**SUBJECT:**	**HOSPITAL ADMISSION FROM THE CENTER**
REVISION DATE:	**03/13**		

Department Approval:	**06/16**
~~MEDICAL/DEPARTMENT:~~	**~~3/13~~**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**
Division of Oncology Approval:	**03/17**
~~Pharmacy and Therapeutics Approval:~~	**~~07/17~~**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. This policy delineates the procedure for an unplanned admission to the hospital directly from the **Outpatient Infusion Center** (Center).

B. **POLICY:**

1. Patient admissions to **Tri-City Healthcare District (TCHD)**~~the hospital~~ from the Center will be done in a safe and efficient manner. The Center Medical Director will discuss the recommendation to admit the patient with the patient/family and the patient's ~~primary~~ physician/**Allied Health Professional (AHP)**.

C. **PROCEDURE:**

1. Upon evaluation by the Center Medical Director, if admission is deemed necessary, orders for admission will be generated.
   a. The Center Medical Director will contact the patient's ~~primary~~ physician/**AHP** to discuss his/her recommendation to admit the patient (if the patient is not triaged to the **Emergency Room**).
   b. If the ~~primary~~ physician/**AHP** concurs, the patient will be admitted under the care of the ~~primary~~ physician/**AHP**.
   c. The admitting department/nurse will be notified immediately by the support staff/receptionist about the pending admission.
   d. A copy of pertinent medical, demographic and treatment information will be provided.
   e. The **Registered Nurse** (RN)/case manager will provide a verbal report to the unit nurse to ensure continuity of care.
   f. The RN/case manager will act as liaison between the hospital and the family and answer any questions that might arise about the unplanned admission.
   g. If the patient is not accompanied by family or significant other, the RN/case manager will make the appropriate notifications.
   h. If the patient is a resident of an extended care facility, the RN/case manager will notify the director of nursing or designee about the pending admission.
   i. The surgeon and/or the surgeon's office will schedule any surgical procedures planned during the hospital admission.
   j. The patient will be kept in the Center and closely monitored until notified by the hospital admitting department or designated nursing unit. After clinic hours, the nursing supervisor will provide instructions for patient disposition.

k. The RN/case manager will coordinate the transfer of the patient to the designated nursing unit with a member of the Center staff and transport personnel, until the designated nursing unit officially receives the patient.

l. If the patient is unstable and cannot be admitted immediately to an acute care bed, the patient will be transferred to the ER after the ER has been notified.

Tri-City Medical Center	Distribution: Outpatient Infusion
~~PROCEDURE:~~	~~OUTPATIENT SUMMARY LIST PROCED~~ **DELETE – No longer required**
~~Purpose:~~	~~To provide ongoing documentation for cont~~
~~Supportive Data:~~	~~This process is unique to Tri-City Medical Center and is not included in Perry & Potter.~~
~~Equipment:~~	~~Outpatient Summary List Form 6185-1002~~

~~A. **POLICY**: Tri-City Medical Center is committed to providing continuity of care to the outpatient population. The Outpatient Summary List (OPSL) or Inpatient/Outpatient Summary List in Cerner will facilitate this continuity of care over a period of time by keeping current information regarding patient's diagnoses, procedures, medications, and allergies. This information will be available to all caregivers and is quickly and easily available to staff.~~

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

~~1. The OPSL or Inpatient/Outpatient Summary List in Cerner will be used in the following areas:~~
- ~~a. Outpatient Chemotherapy~~
- ~~b. Outpatient Infusion Center~~
- ~~c. Special Procedures Recovery Area (SPRA)~~
- ~~d. Cath Lab~~
- ~~e. Interventional Radiology~~
- ~~f. Dialysis Unit (4 Pavilion)~~

~~2. Areas that utilize the paper OPSL:~~
- ~~a. The registered nurse will complete the Outpatient Summary List (Form #6185-1002) by the patient's third visit (may be completed earlier).~~
- ~~b. At the completion of the visit, the OPSL will be sent to Medical Records with the patient's medical record and a copy made and placed in unit file.~~
- ~~c. At each subsequent visit, the registered nurse will retrieve the copy of the OPSL from the unit file and update. Any changes will be lined out with a single line, and additions made as appropriate. The RN shall sign/date the form.~~
- ~~d. At the completion of the visit, a copy is made of the revised OPSL and placed in the unit file. The revised original shall be sent to Medical Records along with the discharged encounter.~~
- ~~e. Units will purge the OPSL file quarterly by shredding.~~

~~3. Areas that utilize the Cerner Inpatient/Outpatient Summary List will have information automatically populated on this list in the following way:~~
- ~~a. The Outpatient History form will be completed for each encounter which updates the problem list, surgeries and procedures, allergies as well as other key information.~~
- ~~b. The Medication History will be completed for each encounter.~~
- ~~c. Key data on the Inpatient/Outpatient Summary List will carry forward between patient encounters.~~

~~4.~~1. ~~Other outpatient units not addressed in this procedure will develop and maintain their own forms per their unit specific procedures.~~

Department Review	Division of Oncology	Pharmacy and Therapeutics	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/13	03/17	07/17	03/13, 08/17	09/17	03/13

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~- OCEANSIDE POLICY MANUAL~~

ISSUE DATE: 03/13 **SUBJECT: PATIENT DISCHARGE**

REVISION DATE: 03/13

Department Approval:	**06/16**
~~MEDICAL/DEPARTMENT:~~	**~~3/13~~**
~~DIRECTOR APPROVAL:~~	**~~3/13~~**
Division of Oncology Approval:	**03/17**
~~Pharmacy and Therapeutics Approval:~~	**~~07/17~~**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. To establish the requirements for patient discharge from the Outpatient Infusion Center **(Center)**.

B. **POLICY:**

1. All ~~Infusion~~ Center patients will be assessed prior to discharge and results documented in the patient's medical record.

C. **GENERAL GUIDELINES:**

1. Patients will be discharged from the ~~Infusion~~ Center when the following criteria are met:
   a. Stable vital signs.
   b. Free from signs and symptoms of adverse reactions including severe nausea/vomiting.
2. Patients should have adequate muscular strength, endurance, functional capacity and body composition for activities of daily living and occupational needs, or have assistance for these activities at home.
3. Patients should have satisfactory understanding of the following:
   a. Basic pathophysiology of their disease and treatment.
   b. Medication information including possible adverse effects.
   c. Contact information for the Center and for treating physician.
4. Patients will be given printed discharge instructions.
5. A discharge summary will be sent to the referring physician/**Allied Health Professional** upon completion of treatment.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER ~~- POLICY MANUAL~~

ISSUE DATE: 03~~2~~/13 **SUBJECT: PHYSICIAN ORDERS / REQUEST FOR SERVICES ORDERS**

REVISION DATE: 03/13

Department Approval:	**06/16**
~~**MEDICAL/DEPARTMENT:**~~	~~**3/13**~~
~~**DIRECTOR APPROVAL:**~~	~~**3/13**~~
Division of Oncology Approval:	**03/17**
~~**Pharmacy and Therapeutics Approval:**~~	~~**07/17**~~
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**03/13**

A. **PURPOSE:**

1. This policy defines the circumstances in which a physician/**Allied Health Professional** orders or requests for services to the **Outpatient Infusion Center (Center)**~~Clinic~~.

B. **POLICY:**

1. Only physicians/**AHPs**~~healthcare professionals~~ granted hospital medical staff privileges may provide written, telephone or verbal orders for patients being seen at the **Center**~~Clinic~~.
2. The clinical staff will take orders only from the **Center**~~Clinic~~ physician/**AHP**.
3. Any treatment/procedure may not be performed without the physician's/**AHP's** written, verbal or telephone instruction unless defined by policy and/or falls within the scope of nursing practice, as mandated by the State of California.
4. Orders for patients not being seen by the physicians/**AHPs** at the **Center**~~Clinic~~ may not be accepted or implemented by the clinical staff.
5. Hospital policy will be followed when implementing physician's/**AHP's** orders.

C. **PROCEDURE:**

1. When the physician/**AHP** is on site, orders will be written and signed by the physician/**AHP** after each clinic visit.
2. Verbal orders may be taken by the licensed clinical staff at the direction of the **Center**~~clinic~~ physician/**AHP** caring for the patient **in an emergent situation only**.
3. All physician/**AHP** orders will be **reviewed** ~~noted~~ by a registered nurse according to **Tri-City Healthcare District (TCHD)**~~hospital~~ policy.

Tri-City Medical Center
Oceanside, California

PHARMACY ~~MANUAL~~

ISSUE DATE: 09/11

SUBJECT: Transdermal Fentanyl Patch Prescribing and Use

REVISION DATE: 03/15

POLICY NUMBER: 8390-6020

Departmental Approval:	**~~05/15~~07/17**
Pharmacy & Therapeutics Committee Approval:	**~~10/11, 05/15~~07/17**
Medical Executive Committee Approval:	**~~11/11, 07/15~~08/17**
Professional Affairs Committee Approval:	**~~08/15~~09/17**
Board of Directors Approval:	**08/15**

A. **PURPOSE**:
1. To provide a guideline summarizing safe use practices to reduce the preventable harm to patients in the hospital setting.

B. **POLICY**:
1. Due to the Food and Drug Administration (FDA) black box warning, this policy and procedure restricts prescribing to opioid-tolerant patients for the management of persistent, moderate to severe chronic pain that requires continuous, around the clock opioid administration for an extended period of time AND cannot be managed by other means such as nonsteroidal anti-inflammatory drugs, opioid combination products, or immediate-release opioids. Fentanyl patch use in non-opioid tolerant patients has resulted in fatal respiratory depression.
2. Fentanyl patches are not to be used to treat sudden, occasional or mild pain, or pain after surgery.
3. Fentanyl patches should not be prescribed for opioid naïve patients receiving comfort care measures or end of life management Patients must meet the Tri-City Medical Center Criteria for use of Fentanyl Transdermal System (see appendix II) and follow dosing guidelines in order to receive fentanyl patches.

C. **PROCEDURE**:
1. **Prescribing:**
   a. Upon receiving an order for fentanyl patches the pharmacist shall evaluate the following:
      i. Determine if patient is continuing therapy for chronic pain.
      ii. Determine if the patient is opioid tolerant, defined as:
         1) Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR ~~(~~another opioid at a dose comparable to a fentanyl patch **per the Fentalnyl (Duragesic) Dose Conversion Guidelines**~~see appendix I)~~ for 7 days or longer.
      iii. Determine if the patient has any absolute contraindications for use:
         1) Patients who are not opioid tolerant as defined above.
         2) Management of postoperative pain.
         3) Management of mild pain or intermittent pain.
         4) Management of acute pain or if opioid analgesia is only needed for a short period of time (less than 7 days).
      iv. Determine if the patient has any relative contraindications for use:
         1) Concomitant use with ketoconazole, erythromycin, nefazodone, diltiazem or grapefruit juice requires careful monitoring and may require adjustment in fentanyl dosage.

2) Transdermal fentanyl may not be appropriate for patients with fever, diaphoresis, cachexia, morbid obesity, and ascites, all of which may have a significant impact on the absorption, blood levels, and clinical effects of the drug.

b. Pharmacist will then verify the following and if necessary, change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline:
   i. Fentanyl patch is prescribed at the lowest dose needed for pain relief.
   ii. First-time doses (new starts) should not exceed 25mcg/hr unless recommended by pain specialist or approved by Clinical Manager. Fentanyl patch 12 mcg/hr should be considered for elderly or frail patients.
   iii. Consider concomitant opiates and other medications known to have additive CNS or respiratory depression effects in evaluating the appropriateness of the dose.
      1) Discontinue or taper all other around-the-clock or extended release opioids when initiating therapy with fentanyl transdermal patch.
   iv. In selecting an initial dose, attention should be given to the following:
      1) Daily dose, potency, and characteristics of the opiate the patient has been taking previously.
      2) Reliability of dose conversion guidelines to predict the potency of the fentanyl dose needed.
      3) Patient's medical status.
      4) To account for incomplete cross-tolerance, a 25% dose reduction is needed when switching among opiates in patients whose pain is well controlled. No reduction is necessary in patients with poorly controlled chronic pain. For patients who have acute pain but whose chronic pain is otherwise controlled, a 25% dose reduction is still needed.
   v. Frequencies of q48h are generally not recommended.
      1) Frequencies of Q48h may be appropriate for a small number of adult patients and may be evaluated on a case-by-case basis. Such frequencies will not be allowed for new starts unless approved by the Clinical Manager.
   vi. During dose titration, increasing dosages shall not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes.
      1) Titrate dose based on the daily dose of supplemental opioids required by the patient on the second or third day of the initial application.
      2) Dose should be increased in 25 mcg increments. Larger increments may be considered for some patients on high doses if prescribed and followed by pain specialist.
      3) Dose increases are not appropriate for patients who have acute pain but whose chronic pain is otherwise controlled. Such pain should be managed by appropriate use of breakthrough analgesia.
   vii. When discontinuing transdermal fentanyl and not converting to another opioid, use a gradual downward titration, such as decreasing the dose by 50% every 6 days to reduce risk of withdrawal symptoms.
      1) For disposal of fentanyl patches see Patient Care Services Controlled Substances Management Policy.

c. The pharmacist reviewing the order will document the following:
   i. Verification of inclusion criteria.
   ii. Initial dose and date/time of initiation.
   iii. Validation of inpatient and outpatient drug dosing history (including last refill information).
   iv. Any potential drug interactions.
   v. Discussions with prescriber, if any.

2. Dispensing and Labeling:

a. Fentanyl patches will been set up as a patient specific medication.
b. Do not cut patch warning will be placed in MAR notes.
c. Tall man lettering will be used fentanyl.

3. Monitoring:
   a. Patient monitoring for opioid related side effects will be performed by nursing staff as per the Pain Management Patient Care Services Policy.
   ~~a. Pharmacist will assess for signs and symptoms of opioid-related side effects (confusion, sedation, respiratory depression, hemodynamic instability) throughout the use of the fentanyl patch or until patient discharge, with special emphasis on the initial 24 hours after patch placement or after dose increases.~~
   ~~b. If a patient is showing symptoms of excessive opioid-related side effects (respiratory distress; shallow breathing; tiredness; extreme sleepiness, or sedation; inability to think, talk or walk normally; feeling faint, dizzy, or confused)~~
      ~~i. Notify the patient's primary Registered Nurse or call a Rapid Response based on the patient's condition.~~
      ~~ii. Contact provider for orders to remove/adjust dose of the fentanyl patch and/or adjust breakthrough pain medication. Upon discontinuation, approximately 17 hours are required for a 50% decrease in fentanyl levels.~~

D. **RELATED DOCUMENT(S):**
1. Fentanyl (Duragesic) Dose Conversion Guidelines
2. Tri-City Medical Center Criteria for Use of Fentanyl Transdermal System
3. Patient Care Services Controlled Substances Management Policy

E. **REFERENCE(S)**:
1. ISMP Medication Safety Alert! Community/Ambulatory Care Edition. Volume 13, Issue 3. March 2014
2. Acute Care ISMP Medication Safety Alert! Ongoing, Preventable Fatal Events with Fentanyl Transdermal Patches are Alarming! June 28, 2007.
3. CHA Medication Safety Committee High Alert Medication Guideline- Fentanyl Transdermal Patch. April 2011.
4. Grissinger, Matthew. Inappropriate Prescribing of Fentanyl Patches is Still Causing
5. Alarming Safety Problems. Pharmacy and Therapeutics. 2010; 35(12): 653-654.
6. Lexicomp, Inc. (Lexi-DrugsTM). Lexicomp. ~~April 27~~**July 5**, 201~~5~~.

FENTANYL (DURAGESIC) DOSE CONVERSION GUIDELINES

Current Analgesic	Daily dose mg/day	Daily dose mg/day	Daily dose mg/day	Daily dose mg/day
Oral morphine	60 – 134	135 – 224	225 - 314	315 - 404
IM/IV morphine	10 – 22	23 – 37	38 – 52	53 – 67
Oral oxycodone	30 – 67	67.5 – 112	112.5 – 157	157.5 – 202
IM/IV oxycodone	15 – 33	33.1 – 56	56.1 – 78	78.1 – 101
Oral codeine	150 – 447	448 – 747	748 – 1047	1048 – 1347
Oral hydromorphone	8 – 17	17.1 - 28	28.1 – 39	39.1 – 51
IV hydromorphone	1.5 – 3.4	3.5 – 5.6	5.7 – 7.9	8 – 10
IM meperidine	75 – 165	166 – 278	279 – 390	391 – 503
Oral methadone	20 – 44	45 – 74	75 – 104	105 – 134
IM methadone	10 – 22	23 – 37	38 – 52	53 – 67
Recommended Fentanyl Transdermal System Dose	25 mcg/hr	50 mcg/hr	75 mcg/hr	100mcg/hr

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 08/97

SUBJECT: PULMONARY – SCOPE OF SERVICES

REVISION DATE(S): 08/97, 01/00, 09/03, 08/06, 09/08, 09/09, 11/11, 05/12

Department Approval:	03/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	08/17
Professional Affairs Committee Approval:	09/17
Board of Directors Approval:	~~01/10,~~ 05/12

A. **OVERVIEW OF THE DEPARTMENT:**

1. The department of pulmonary services provides diagnostic and therapeutic services to inpatients, outpatients, and emergency department patients under the direction of a licensed pulmonary physician. Services are provided to neonates, infants, adolescents, adult and geriatric age groups. Service settings include all hospital areas. Pulmonary services ~~proved~~ **provide** a 24-hour/7 day service designed to meet the needs of our patients.

B. **DIAGNOSTIC SERVICES INCLUDE:**

1. Pulmonary function testing (outpatients scheduled 2 **days** ~~3 days~~/week: ~~Tuesday~~ **Wednesday**–Thursday and inpatients as ordered).
2. Non-invasive oxygen assessment (Pulse Oximetry).
3. Home oxygen assessment.
4. Blood gas sampling and analysis.
5. Sleep screening (limited sleep ~~study~~ **screen**– inpatients only).
6. Bronchoscopy.
7. **CPAP set up and education**
8. ~~EKGs.~~

C. **THERAPEUTIC SERVICES INCLUDE:**

1. Patient pulmonary assessment.
2. Patient respiratory education.
3. Medical gas administration.
4. Aerosol therapy.
5. Hyperinflation therapy.
6. Pulmonary hygiene.
7. Airway maintenance and support.
8. Ventilatory support.
9. CPR.
10. ~~*Exception:* Full sleep studies are not performed at TCMC. Patients are referred to Palomar or Scripps.~~

D. **PROVIDERS OF SERVICE:**

1. All providers of respiratory therapy are appropriately oriented to the department and are licensed as required by law. Respiratory Care Practitioners (RCPs) acquire additional training and continuing education to ensure the proper care of patients. RCPs function under the direction of a medical director who specialize~~d~~**s** in pulmonary medicine. The medical director

acts in that role for ~~one~~ **two** years as described in the medical center by-laws. RCPs also function under the direction of an operations manager and director.

2. The pulmonary services department staff work in 12-hour shifts. The number of staff scheduled each shift is based on **the** total **workload calculated from the Respiratory Therapy Workload Summary report.** ~~RVUs or "sums" which are reviewed as part of the department information management system, "Medi-Serve."~~
3. Qualified RCPs are available 24 hours a day, 7 days a week on site. ~~RCPs re4port to a lead therapist or shift supervisor on both shifts.~~
4. ~~Additional~~ **M**~~m~~embers of the pulmonary management services team include the following:
   ~~3.~~ ~~RCP coordinators:~~
   ~~a.~~ ~~Clinical educator.~~
   a. Pulmonary Manager
   b. ~~ICU coordinator~~**Dayshift supervisor(s)**
   c. Nightshift supervisor(s).
   d. Clinical Educator

~~4.~~**5.** ~~The role of the RCP at Tri-City Medical Center and additional pulmonary support staff is described in the job descriptions and policies and procedures.~~ The department of pulmonary services is composed of professional, technical, clerical, and support staff in the following categories:

a. Director
b. ~~Ops~~ **Operations /Clinical** manager
c. Educator
~~d. Coordinator~~**Supervisors**
~~e. Leads~~
~~f.~~**d.** Registered/**C**~~c~~ertified pulmonary function technologists
~~g.~~**e.** Registered respiratory therapists (RRTs)
~~h.~~**f.** Certified respiratory therapists (CRTs)
g. Cardiopulmonary assistants (equipment technicians)

~~i.~~**6. Job descriptions are on file for each of the above job categories.**

E. **EQUIPMENT:**

1. The pulmonary services department provides services utilizing medical equipment that is maintained in proper operational condition per preventative maintenance schedules and manufacturer's recommendations. Equipment inventory includes disposable and non-disposable equipment.

F. **STANDARDS AND PRACTICE GUIDELINES:**

1. Effective and efficient patient care is provided based on current standards of respiratory care and practice. TCMC pulmonary services adheres to federal and state regulatory imperatives and standards including the Respiratory Care Practice Act, Title 22, and Title 17, Center for Disease Control (CDC) and OSHA, and JCAHO. Patients can expect care that is delivered in a manner consistent with the American Association of Respiratory Care (AARC) Guidelines for Therapy whereby patients are assessed so that individual needs are met. The patient is evaluated to ensure that therapy is appropriate, indicated, and objectives clearly defined.
2. Patients and patient families can expect to be treated with dignity and respect (per "Patients' Rights") by the RCPs who also provide education and explanation of services for their customers.
3. In addition to the national guidelines, policies/procedures and protocols are based on expert consensus, documentation team review and community standards. Policies and procedures are reviewed ~~every year~~ and revised as needed to accommodate new evidence, standards, and/or guidelines. Policies are discussed among the management team with input from RCPs then the hospital documentation team before they are finalized. Final versions are communicated to the staff through email, staff meetings, ~~notes on bulletin boards, and "lunch" and "dinner" meetings~~**and daily huddles on each shift**.

~~3.~~4. All policies and procedures are posted online after submitting to house wide review and board approval.

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

SUBJECT: Respiratory Medication Administration

ISSUE DATE: 05/09
REVISION DATE(S): 09/09, 01/12, 06/15

Department Approval:	**~~09/09, 1/12, 7/15~~08/16**
Medical Staff Pulmonary Division:	**04/17**
Pharmacy and Therapeutics Approval:	**07/17**
Medical Executive Committee Approval:	**08/17**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval	

~~A. DEFINITION(S):~~
~~1. RCP= Respiratory Care Practitioner~~

~~B.~~**A. POLICY**:
1. Respiratory medication treatments will be rendered as close to the Respiratory medication standard times as possible~~,~~. ~~although the fact that a single RCP may be assigned as many as 10-12 patients a day makes it impossible to provide all treatments at the exact prescribed times.~~ Patient diagnostic testing, meals trays, Codes, Rapid Response calls and urgent PRN (as needed) calls may impact the times that therapy is being provided.
2. The **Respiratory Care Practitioner (**RCP**)** may stagger times to keep the intervals between treatments appropriate.
3. The general expectation is that treatments will be given within one hour before or after the targeted treatment scheduled time.

~~C.~~**B. PROCEDURE**:
1. The RCP will stay with the patient during the treatment with the exception being the Emergency department and ICU where close monitoring is provided ~~by both RN's and RCP's.~~
2. Patients may be treated concurrently if they are in the same room with the RCP using proper infection control techniques.
~~3. The RCP's may only review medications for inhalation.~~
~~4.~~**3.** The RCP must compare the Medication Administration Record (MAR) and ~~the medication shown on the Care Mobile device to~~ the physician's medication order **to ensure accuracy**.
~~5. The Pharmacist is the primary review of the physician's medication orders and then the RCP or RN is the second licensed verification on inhalation medications.~~
~~6. RCP's may perform the Clinician review on the Care Mobile device for inhalation medications~~.
~~7.~~**4.** Below is the table listing the Respiratory therapy Medication times:

Rx Frequencies	Times Given
RT Daily (1/Day)	0900
RT QAM (1/Day)	0900
RT BID (2/Day)	0900-2100
RT TID (3/Day)	0900, 1500, 2100
RT QID (4/Day)	0800, 1200, 1600, 2000
RT Q4h (Every 4 hours)	0700, 1100, 1500, 1900, 2300, 0300
RT Q6h (Every 6 hours)	0900, 1500, 2100, 0300
RT Q8h (Every 8 hours)	0800, 1600, 2400
RT Q12h (Every 12 hours)	0900, 2100
W/A (While awake)	Rx will be given routinely during daylight hours 0700-2000. If the patient requires therapy during the night, it may be given.
PRN (As needed)	Patient request/RN or RCP judgment.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

SUBJECT: **Emergency Care – ~~2124 El Camino Real~~Outpatient Services**

ISSUE DATE: **07/91**
REVISION DATE(S): **02/94, 09/97, 10/00**

Department Approval:	**08/16**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**09/17**
Board of Directors Approval:	**01/15**

~~**ISSUE DATE:** 7/91~~	~~**SUBJECT: EMERGENCY CARE – OUTPATIENT SERVICES 2124 El Camino Real, Oceanside**~~
~~**REVISION DATE:** 2/94, 9/97, 10/00~~	~~**STANDARD NUMBER: 1504**~~
~~**REVIEW DATE:** 2/03, 1/06, 1/09, 4/12~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL: BOARD OF DIRECTORS APPROVAL: 01/15**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

- ☐ ~~4002 Vista Way, Oceanside, CA~~
- ☑ ~~2124 El Camino Real Suite 100, Oceanside, CA~~
- ☐ ~~6250 El Camino Real, Carlsbad CA~~
- ☐ ~~3861 Mission Ave B25, Oceanside, CA~~
- ☐ ~~510 Hacienda Drive 108A, Vista, CA~~

~~A. **PURPOSE:**~~
~~To provide emergency services to patients in the Outpatient Rehabilitation Services Department located at 2124 El Camino Real~~

~~B.~~**A. POLICY:**

1. All emergency medical, fire and law enforcement situations occurring at the Rehabilitation Services Outpatient Department **and the Wellness Center** will be provided by city emergency response systems~~. of the City of Oceanside.~~

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

1. In case of any medical, fire or law enforcement emergency, staff members will initiate appropriate interventions such as assessing vital signs, initiating CPR, RACE, etc., as indicated per Departmental Policy, and dial 911 for assistance, specifying outpatient location.
~~1.~~**a. Notify main hospital for fire or other emergencies.**

~~1.~~**2.** Appropriate documentation of each incident will be completed by Rehabilitation **Staff members, including notifying the patient's physician when the incident involves a patient.**
~~a. Staff members, including notifying the patient's physician when the incident~~
~~b. involves a patient.~~

~~2.~~**3.** Follow-up on patient status/outcome is documented in the medical record.

Tri-City Medical Center
Oceanside, California

Delete- no longer needed

REHABILITATION SERVICES

SUBJECT: Movies/Videos -- TR **POLICY NUMBER:** 902

ISSUE DATE: 09/91
REVISION DATE(S): 8/97, 4/12, 5/12

Department Approval:	08/15
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	09/17
Board of Directors Approval:	

~~**ISSUE DATE:** 9/91~~	~~**SUBJECT:** Movies/Videos -- TR~~
~~**REVISION DATE:** 8/97, 4/12, 5/12~~	~~**STANDARD NUMBER:** 902~~
~~**REVIEW DATE:** 2/03, 1/06, 1/09~~	~~**CROSS REFERENCE:**~~
	~~**APPROVAL:**~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

~~☑ 4002 Vista Way, Oceanside, CA~~

~~☐ 2124 El Camino Real, Suite 100, Oceanside, CA~~

~~☐ 6250 El Camino Real, Carlsbad CA~~

~~A. PROCEDURE~~

~~1. The opportunity will be provided for patients to view a variety of movies and/or videos.~~

~~B. GOALS~~

~~1. To increase sensory stimulation.~~
~~2. To increase socialization skills.~~
~~3. To provide an opportunity for passive participation.~~
~~4. To stimulate environmental awareness.~~
~~5. To provide opportunities for educational development to assist with a healthy lifestyle.~~

~~C. PROCEDURE~~

~~1. Movies/videos shall last from 30 minutes to 2 hours (may include several short videos or 1 full-length video).~~
~~2. Patients will be encouraged to remain quiet throughout the entire program.~~
~~3. Patients will have input into the selection of the movies/videos via individual suggestions and group discussions.~~
~~4. Movies/videos shall be appropriate to age, group, and patient interests.~~
~~5. Following the movie/video, discussion will occur regarding the content and information shared.~~
~~6. Movies/videos may be rented by Therapeutic Recreation staff and/or brought in by family members. All movies/videos must be approved by staff prior to viewing.~~

~~D. MATERIALS~~

~~1. These may include VCR, DVD, computer, monitor, electrical outlet, video/movie, or other gaming/DVD-playing console. Refreshments are optional.~~

E. CRITERIA
1. Patients must be free from other scheduled programming.
2. Patient must be able to sit quietly for long periods of time (1½-2 hours).
3. Patients who wander or exhibit behavioral problems must attend with staff supervision.

F. ADAPTATIONS
1. Sound will be monitored for those clients who are hard of hearing.

G. GROUP SIZE
1. Limited only by size of room.

H. EVALUATION
1. Patient response to movies/videos shown will be documented in weekly progress notes.

PROCEDURE: _____

DIAGNOSIS: _____

ALLERGIES: _____

STATUS: ☐ INPATIENT ☐ OUTPATIENT

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

MEDICATIONS:

Given by MD in CCL:

- ☐ Lidocaine 1% injectable for local anesthetic
- ☐ ~~Sodium bicarbonate 4.2% injectable with anesthetic~~
- ☐ Heparin 1,000 units / mL,10 mL to scrub table
- ☐ Cefazolin (Ancef 1) gram in 250mL of normal saline for pocket irrigation to scrub table
- ☐ Nitroglycerin 100 mcg / mL to scrub table
- ☐ Nicardipine 100 mcg / mL to scrub table
- ☐ Other: _____
- ☐ Other: _____

Given by RN in CCL:

- ☐ Cefazolin (Ancef) ~~1~~ **2** gram IVPB ~~x 1 dose~~ **once**
- ☐ Clopidogrel (Plavix) 600 mg PO ~~**x 1 dose**~~ **once**
- ☐ Prasugrel (Effient) 60 mg PO ~~**x 1 dose**~~ **once**
- ☐ **Ticagrelor (Brilinta) 180 mg PO ~~x 1 dose~~ once**
- ☐ **Bivalirudin (Angiomax) bolus_____mg/kg and drip at _____mg/kg/hour**
- ☐ **Eptifibatide (Integrilin) 180 mcg/kg bolus (max 22.6 mg) Q 10 minutes ~~x2 doses~~ times two doses**
- ☐ **Eptifibatide (Integrilin) drip at ☐ 2 mcg/kg/min (max 15 mg/hr) OR ☐ 1 mcg/kg/min (max 7.5 mg/hr)**
- ☐ Meperidine (Demerol) 12.5 mg – 100 mg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD
- ☐ Fentanyl (Sublimaze) 25 mcg – 100 mcg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD
- ☐ Morphine 2 – 10 mg IVP Q 5 minutes PRN Procedural Pain/Sedation as directed by MD
- ☐ Midazolam (Versed) 0.5 mg – 5 mg IVP Q 5 minutes PRN Pain/sedation as directed by MD
- ☐ Naloxone (Narcan) 0.4 mg IVP on call to reverse sedation post procedure if needed
- ☐ Flumanzenil (Romazicon) 0.2 mg IVP on call to reverse sedation post procedure if needed
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

☐ Read Back all T.O./V.O.orders					
Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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

Affix Patient Label

8711-4010

CARDIAC CATH LAB MEDICATION ORDERS

☐ **Tri-City Medical Center**
4002 Vista Way, Oceanside CA 92056
Phone: 760-940-3098, Fax 760-940-4056

☐ **Carlsbad Wellness Center**
6250 El Camino Real, Carlsbad CA 92008
Phone: 760-476-2905, Fax 760-931-3163

Patient Name: _____ DOB: _____

Home Phone: _____ Cell: _____

DIAGNOSIS: **Date of Onset or Intervention:**

- ☐ Acute Myocardial Infarction STEMI (within 1 year of infarction) _____
- ☐ Non-STEMI (within 1 year of infarction) _____
- ☐ Coronary Artery Bypass Graft surgery _____
- ☐ Stable Angina Pectoris _____
- ☐ Heart Valve Repair or Replacement _____
- ☐ CHF (EF documented < 35%) _____
- ☐ Percutaneous Transluminal Coronary Angioplasty _____
- ☐ PTCA with Coronary Artery Stenting _____
- ☐ Heart Transplant _____
- ☐ Phase IV Supervised Maintenance Program (Oceanside site only) _____

PROGRAM OPTIONS / TREATMENT PLAN:

☐ Phase II Continuous Telemetry Monitored Cardiac Rehab, duration based on patient progress to a maximum of 36 sessions in 12-18 weeks:
- Initial Evaluation Nursing Assessment
- Progressive exercise training 3 times per week, 30-60 minutes per session; utilizing treadmill, stationary bike, hand weights, steps/recumbent stepper, elliptical, and other conditioning activities
- Education to promote an active healthy lifestyle and reduction of personal health risk factors

INTENSITY:

☐ Patient will be exercised to tolerance with the following restrictions:
- ☐ None
- ☐ Based on Stress Test, completed on _____
- ☐ Heart Rate Range: _____ - _____
- ☐ Maximum Heart Rate: _____

Restrictions: _____

☐ My patient does not require a graded exercise test prior to starting the cardiac rehab program.
☐ My patient has had a graded exercise test and we will fax it to the Cardiac Wellness Program.
☐ My patient is able to participate in the cardiac rehabilitation MAINTENANCE program, where he/she will only be ECG monitored for 3 visits. This option is self-pay, and no insurance authorization is necessary. All fees will be the responsibility of the patient (Oceanside site only).

☐ Phase IV Cardiac Rehab Maintenance Program (Oceanside site only)

☐ Supervised exercise without Telemetry monitoring

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

Affix Patient Label

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

CARDIAC REHABILITATION PHYSICIAN REFERRAL ORDERS

PHYSICIAN'S ORDERS

DIAGNOSIS: _____

PROCEDURE: _____

ALLERGIES: _____

ADMIT TO: ☑ Labor & Delivery

CODE STATUS: ☐ Full ☐ No Resuscitation for hospital duration*
*Requires notation in Progress Notes.

ASSESSMENT:
- ☐ Electronic Fetal Monitoring
- ☐ Check FHT in OR prior to surgery, before abdominal skin prep

DIET:
- ☐ NPO **after midnight**
- ~~☐ Regular Diet~~

LAB/DIAGNOSTICS:
- ☐ Comprehensive Metabolic Panel (C12)
- ☐ CBC
- ☐ Type and screen ☐ Type and cross _____ units
- ☐ **Capillary Blood Glucose upon admission for patients with Diabetes**
- ☐ Other: _____
- ☐ Other: _____

MEDICATIONS:
- ~~☐ Antibiotic~~
- ☐ **Cefazolin** (Ancef) 2G IV**PB to be sent to OR with patient. To be** given by Anesthesiologist ~~before cut~~ **prior to incision.**
- ☐ **Cefazolin (Ancef) 3g IVPB for patients weighing greater than or equal to 120kg. To be sent to OR with patient. To be given by Anesthesiologist prior to incision.**
- ☐ Clindamycin **(Cleocin)** 900 mg **IVPB to be sent to OR with patient. To be given by Anesthesiologist prior to incision.**

IV:
- ☑ Start IV with 18 gauge catheter.
- ☑ Infuse Lactated Ringers at 500 mL per hour X 2 hours, then at 125 mL per hour.

CONSULT:
- ☑ Notify anesthesia of patient's admission.

TREATMENT:
- ☐ Abdominal Prep
- ☐ Insert #16 Foley catheter prior to surgery.

CONDITIONS:
- ☐ No additional DVT Prophylaxis required at this time ☐ DVT Anticoagulation Prophylaxis contraindicated.
  Explain: _____

NON-MEDICATION DVT PROPHYLAXIS:
- ☐ Sequential compression device knee high ~~☐ Bilateral ☐ Right ☐ Left~~

CAUTION IF USING THIS PROTOCOL FOR PRESCRIBING HEPARIN OR ENOXAPARIN IF PLATELETS LESS THAN 100,000/mcL.

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time
Tri-City Medical Center 4002 Vista Way • Oceanside • CA • 92056 8711-4010 **OB SCHEDULED C-SECTION ~~DOWNTIME~~ ORDERS ~~SHEETS~~** **Page ~~21~~ of ~~21~~**	Affix Patient Label

MODERATE TO HIGH RISK ~~(Including general surgery, hip fracture surgery, total hip replacement, and total knee replacement)~~:

- ☐ Enoxaparin (Lovenox) 30 mg subcutaneous upon admission.
- ☐ Enoxaparin (Lovenox) 40 mg subcutaneous upon admission
- ☐ Heparin 5,000 units subcutaneous upon admission

☐ Read Back all T.O./V.O.orders

Nurse's – Signature	Date	Time	Physician's – Signature	Date	Time

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

Affix Patient Label

8711-4010

OB SCHEDULED C-SECTION ~~DOWNTIME~~ ORDERS ~~SHEETS~~

Page ~~21~~ of ~~21~~

DRAFT

Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
September 5, 2017

Members Present:	James J. Dagostino, PT, DPT, Chairperson; Director Laura E. Mitchell; Director RoseMarie V. Reno; Robin Iveson, Community Member; Dr. Cary Mells, Physician Member; Dr. Victor Souza, Chief of Staff
Non-Voting Members:	Steve Dietlin, CEO; Kapua Conley, COO; Scott Livingstone, Interim CCO
Others Present:	Teri Donnellan, Executive Assistant; Jane Dunmeyer, League of Women Voters; Greg Moser, General Counsel; Sherry Miller, Manager, Medical Staff Services
Absent:	Dr. Paul Slowik, Community Member; Dr. Marcus Contardo, Physician Member

	Discussion	Action Follow-up	Person(s) Responsible
1. Call To Order	The meeting was called to order at 12:30 p.m.in Assembly Room 3 at Tri-City Medical Center by Chairman Dagostino. Chairman Dagostino introduced incoming Chief of Staff Victor Souza, M.D.		
2. Approval of Agenda	**It was moved by Director Mitchell and seconded by Ms. Robin Iveson to approve the agenda as presented. The motion passed unanimously.**	Agenda approved.	
3. Comments from members of the public	Chairman Dagostino read the Public Comments announcement as listed on today's Agenda.	Information only	
4. Ratification of prior Minutes	**It was moved by Director Mitchell and seconded by Director Reno to ratify the minutes of the June 6, 2017 Governance & Legislative Committee. The motion passed unanimously.**	Minutes ratified.	Ms. Donnellan
5. Old Business	None		
6. New Business a) Medical Staff Rules & Regulations 1. Department of Pediatrics	Ms. Sherry Miller, Manager of Medical Staff Services requested that the Department of Pediatrics Rules & Regulations be pulled for additional review.	Pediatric Rules & Regulations to be placed on an upcoming agenda.	Ms. Miller

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	Mr. Miller left the meeting at 12:40 p.m.		
b) Review and discussion of Board Policy 14-001 – Budget for Medical Equipment or Medical Services for Tri-City Healthcare District	Chairman Dagostino questioned whether Board Policy 14-001 – Budget for Medical Equipment or Medical Services for Tri-City Healthcare District can be omitted due to the fact that the Medical Staff (via the Chief of Staff) is involved in the strategic and budget planning process. Director Reno commented that the policy should remain a Board Policy. Ms. Iveson suggested the policy be rewritten for grammatical purposes. Dr. Souza questioned if MEC should be included in review of the policy. Dr. Mells requested clarification on how input is given from the Medical Staff. Chairman Dagostino explained the Chief of Staff is the conduit. **It was moved by Ms. Iveson to recommend that the policy language be amended as follows: "The annual proposed Capital Budget for medical equipment or medical services for Tri-City Healthcare District may be presented to the Executive Committee of the Medical Staff of Tri-City Medical Center for consideration and recommendation; to be considered by the Board of Directors of Tri-City Healthcare District prior to any expenditure by any other entity or individual". Director Reno seconded the motion. The motion passed unanimously**	Recommendation to be sent to the Board of Directors to amend Board Policy 14-001 – Budget for Medical Equipment or Medical Services for Tri-City Healthcare District as described; item to be placed on Board agenda and included in Board agenda packet.	Ms. Donnellan
c) Review and discussion of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson	Chairman Dagostino questioned the methodology that was used in determining time limits for Board meetings. Mr. Moser explained it is a self-imposed set of guidelines that the Board established at a time when Board meetings were running extremely late. Mr. Moser further explained it was also designed to protect the public from lengthy meetings. Mr. Moser stated as a practical matter, when time limits are up the Board has the prerogative to continue the meeting or adjourn the meeting. It was recommended the policy stand as written.	No action taken.	

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

d) Review and discussion of Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms	Chairman Dagostino stated Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference rooms has been revised to reflect current practice with regard to scheduling of meeting rooms and fees associated with the meeting rooms. Mr. Conley explained in an effort to reduce operating expenses TCMC has scaled back catered events/meetings. He stated the scheduling function has been broken out into four categories: 1) Board and Auxiliary Room Requests, 2) Non-nursing and Foundation room requests; 3) Nursing and Community Room requests and 4) Medical Staff room requests. It was suggested that the policy reflect the various categories and the position responsible for handling those requests. It was also recommended that the Fee Schedule be evaluated for fair market value. Chairman Dagostino also requested clarification if there are animals other than service dogs that are prohibited. It was recommended that the policy be pulled to address the questions raised and brought back to the committee for consideration.	Policy to be revised and brought back to the committee for consideration. COO to address questions related to fair market value and animals	COO
e) Review and discussion of Bylaws	Chairman Dagostino opened the floor for discussion of the Bylaws. He suggested the words "accrediting agencies" be added to Article I, Section 2. e. Director Mitchell suggested the word "race" be revised to "ethnicity" in Article I, Section 2. a. Mr. Moser suggested language that would conform to the Penal Code or set forth in Education Code section 220 as follows: "... regardless of disability, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code or set forth in Education Code Section 220." Director Reno requested clarification on the Healthcare District Law versus the new voting rights laws. Mr. Moser stated Healthcare District Law has not been		

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	updated for a number of years, thus there are some inconsistencies with state law. Mr. Moser stated more often than not state law would supersede and state law always overrides Bylaws. It was recommended that the last sentence in Article I Section 1, third paragraph be deleted. Director Reno suggested that ACHD update Healthcare District Law. Director Mitchell stated as a member of the ACHD Educational Committee she would make the request of ACHD. Chairman Dagostino requested clarification on Article I Section 4. Disposition of Surplus. Mr. Moser explained this language is a paraphrase from Healthcare District Law and is the underlying reason to include it in the Bylaws. He further explained that the reason it exists is to provide a list of what funds can be used for however it does not prohibit the District from setting up a fund. Ms. Iveson suggested the sentence be broken into two sentences for grammatical clarity. It was recommended that the content of Section 4 remain unchanged. Director Reno requested clarification on Article III Section 10 Quorum related to participation via conference call. Mr. Moser explained there is a separate Board policy that addresses teleconferencing. He stated a quorum of the Board needs to be present within the jurisdiction of the District. A Board member may conference in from a location outside of the District however that individual will not be counted towards a quorum and will not be compensated. He further explained that a Board member who conferences in within the jurisdiction requires the conference be in a location open and posted to the public. Participation by conference within the jurisdiction allows the Board member to be counted towards the quorum and be compensated. Director Reno requested clarification on Article VI, Section 2. Clerk of the Board of Directors. She	Director Mitchell to contact ACHD regarding updating of Healthcare District Law.	Director Mitchell

Topic	Discussion	Action Follow-up	Person(s) Responsible

DRAFT

	questioned if the Executive Assistant is also the Clerk of the Board and whether letters that are received by the Clerk are forwarded to General Counsel. Mr. Moser stated per discussion at a previous meeting reference to the Elections Code Section 307 was included in Section 2 to reflect that the Executive Assistance shall serve as Clerk of the Board of Directors for the purposes of Elections Code 307. Dr. Souza questioned the language in Article III Section 3 f. related to the Medical Staff. Mr. Moser suggested the words "promote, demote" be struck as well as the word "all". Section 3. f. will be revised to read in part "To appoint, approve and remove members of the Medical Staff." Director Reno commented that the Joint Conference Committee was omitted from Article V. Section 2. Mr. Moser clarified that the Joint Conference Committee is a Medical Staff Committee and is not governed by the Brown Act. It was noted that additional changes will be needed to the Bylaws once the District Boundaries have been drawn and approved. **It was moved by Director Mitchell to recommend approval of the Bylaws as amended. Dr. Souza seconded the motion. The motion passed unanimously.**	Recommendation to approve the amended Bylaws; item to be placed on Board agenda and included in Board agenda packet.	Ms. Donnellan
7. Discussion regarding Current Legislation	*Ms. Robin Iveson left the meeting at 1:30 p.m.* Chairman Dagostino reviewed the Key State Issues that were included in today's agenda packet that may have an impact on the District at some point. Mr. Moser reported AB1250 (not listed on today's Key State Issues report) requires counties, or county agencies, to satisfy a set of exceedingly high standards before executing new contract for personal services that	Information only.	

Topic	Discussion	Action Follow-up	Person(s) Responsible
			DRAFT
	are currently or customarily provided by county employees. He stated at this point Healthcare District contracts are exempt however there could be future amendments that would apply the bill more broadly. Discussion was held regarding ACHD's role in following bills. Chairman Dagostino stated Brooks Espinoza is ACHD's contract lobbying firm. He noted CHA tends to provide more comprehensive list. Discussion was held regarding the recent Utah nurse incident with the Utah Police Department. It was recommended that we make sure our policies and protocols on the floors align with both state and federal "implied" consent procedures. Dr. Mells stated he has received the applicable California law from Regulatory Services that states by virtue of a driver's license we allow consent to draw blood. The committee requested a follow-up report at the next meeting.	The COO will provide a follow-up report on implied consent at the next meeting.	COO
8. Review of FY2018 Committee Work Plan	The FY2018 Committee Work Plan was included in the agenda packet for information.	None	
9. Committee Communications	Director Reno suggested when the Chief Compliance Officer is on board that he reviews the Board policies. Director Reno commented on the Community Healthcare & Alliance Grant Committee. Mr. Moser stated the grant process will be discussed at the September 7th Board Workshop.	Information only.	
10. Committee Openings – One	There is currently one opening on the committee.		
11. Confirm date and time of next meeting	The committee's next meeting is scheduled for Tuesday, October 3, 2017 at 12:30 p.m.	The next meeting of the Committee is October 10, 2017.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 1:53 p.m.		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~17-001

POLICY TITLE: **Budget for Medical Equipment or Medical Services for Tri-City Healthcare District**

The annual proposed Capital Budget for medical equipment or medical services for Tri-City Healthcare District may be presented to the Executive Committee of the Medical Staff of Tri-City Medical Center for consideration and recommendation~~,~~; to be considered ~~prior to consideration~~ by the Board of Directors of Tri-City Healthcare District or prior to any expenditure by any other entity or individual.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/08/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Received by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14

Reviewed by the Gov/Leg Committee: 9/5/17

Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT

BYLAWS

Approved ~~June 30~~September 28, 2017

PREAMBLE

The name of this District shall be TRI-CITY HEALTHCARE DISTRICT, organized December 10, 1957, owning and operating TRI-CITY MEDICAL CENTER, under the terms of The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.)

The objectives of this District shall be to promote the public health and general welfare of the communities it serves.

This District shall be empowered to receive and administer funds for the attainment of these objectives, in accordance with the purposes and powers set forth in The Local Health Care District Law of the State of California (H&S Code § 32000 et seq.) and other applicable law.

ARTICLE I

Purposes and Scope

Section 1. Scope of Bylaws.

These Bylaws shall be known as the "District Bylaws" and shall govern the TRI-CITY HEALTHCARE DISTRICT, its Board of Directors, and all of its affiliated and subordinate organizations and groups.

The Board of Directors may delegate certain powers to the Medical Staff and to other affiliated and subordinate organizations and groups, such powers to be exercised in accordance with the respective Bylaws of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups in the Bylaws of such other organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

The Bylaws of the Medical Staff and other affiliated and subordinate organizations and groups, and any amendments to such Bylaws, shall not be effective until they are approved by the Board of Directors of the TRI-CITY HEALTHCARE DISTRICT. In the event of any conflict between the Bylaws of the Medical Staff and any other affiliated or subordinate organization or group, and the provisions of these District Bylaws, these District Bylaws shall prevail. ~~In the event the District Bylaws are in conflict with any statute of the State of California governing hospital and health care districts, such statute shall be controlling.~~

Section 2. Purposes.

The purposes of the TRI-CITY HEALTHCARE DISTRICT shall include, but not necessarily be limited to, the following:

~~a. Within the limits of community resources, to provide the best facilities and services possible for the acute and continued care of the injured and all, regardless of race, creed, national origin, age or disability.~~

a. Within the limits of community resources, to provide the best facilities and services possible for the acute and continued care of the injured and all, regardless of disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code or set forth in Education Code section 220

b. To assure the highest level of patient care in the hospital of the District.

c. To coordinate the services of the District with community agencies and other hospitals providing health care services.

d. To conduct educational and research activities essential to the attainment of its purposes.

e. To do any and all other acts necessary to carry out the provisions of the Local Health Care District Law, accrediting agencies and other applicable law, and District Bylaws and policies.

Section 3. Profit or Gain.

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits, to any individual, under any guise whatsoever, nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. Disposition of Surplus.

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable hospital purposes~~, such as~~. This may include the establishment of free or part-free hospital beds, or for improvements in the hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Law, other applicable law, and District Bylaws and policies.

ARTICLE II

OFFICES

Section 1. Offices.

The principal office for the transaction for the business of the TRI-CITY HEALTHCARE DISTRICT is hereby fixed at TRI-CITY MEDICAL CENTER, 4002 Vista Way, Oceanside, California. Branch offices may at any time be established by the Board of Directors at any place within or without the boundaries of TRI-CITY HEALTHCARE DISTRICT, for the benefit of TRI-CITY HEALTHCARE DISTRICT and the people served by TRI-CITY HEALTHCARE DISTRICT.

Section 2. Mailing Address.

The mailing address of TRI-CITY HEALTHCARE DISTRICT shall be as follows:

TRI-CITY HEALTHCARE DISTRICT
c/o Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056

ARTICLE III

DIRECTORS

Section 1. Number, Qualifications, Election or Appointment.

The Board of Directors shall consist of seven (7) members, who are elected (or appointed) in accordance with the Local Health Care District Law of the State of California, and other applicable law, each of whom shall be a registered voter, residing in the District. The members of the Board of Directors shall be elective officers of the local health care district. (H&S Code §§ 32100 and 32100.5.)

Section 2. Term.

The term of each member of the Board of Directors elected shall be four (4) years, or until his or her successor is elected and has qualified. The person receiving the highest number of votes for each office to be filled at the health care district general election shall be elected thereto. A member of the Board of Directors elected (or appointed pursuant to the provisions of the Uniform District Election Law, Elections Code §§ 10500-10556) shall take office at noon on the first Friday in December next following the District general election. (H&S Code §§ 32002, 32100 and 32100.5; Elections Code § 10554.)

Section 3. Powers and Duties.

The Board of Directors shall have and exercise all the powers of a Health Care District set forth in the Local Health Care District Law (H&S Code § 32000 et seq.), other applicable law, and District Bylaws and policies, as well as the powers listed herein:

a. To control and be responsible for the management of all operations and affairs of the District.

b. To make and enforce all rules and regulations necessary for the administration, government, protection, and maintenance of hospitals and other facilities under District jurisdiction.

c. To appoint the President/Chief Executive Officer and to define the powers and duties of such appointee.

d. To delegate certain powers to the Medical Staff and other affiliated or subordinate organizations in accordance with their respective bylaws. The Medical Staff shall notify the Board of Directors upon election of the Chief of the Medical Staff and of all Chairpersons of the various medical departments and services, whose powers and duties shall be defined by the Medical Staff Bylaws as approved by the Board of Directors.

e. To approve or disapprove all constitutions, bylaws, rules and regulations, including amendments thereto; of all affiliated or subordinate organizations.

f. To appoint, ~~promote, demote~~ approve and remove ~~all~~ members of the Medical Staff. The Medical Staff shall make recommendations in this regard.

g. To establish policies for the operation of this District, its Board of Directors and its facilities.

h. To designate by resolution persons who shall have authority to sign checks drawn on the funds of the District.

i. To do any and all other acts necessary to carry out the provisions of these Bylaws or the provisions of the Local Health Care District Law and other applicable law.

j. To negotiate and enter into agreements with independent contractors, including physicians, paramedical personnel, other agencies and other facilities within the District's jurisdiction. (H&S Code §§ 32121 and 32128.)

Along with the powers of the Board of Directors, it shall be the duty of the Board of Directors to establish rules of the hospitals and other facilities within District jurisdiction, which shall include the following:

aa. Provision for the organization of physicians and surgeons, podiatrists, and dentists, licensed to practice in the State of California who are permitted to practice in the hospitals and other facilities within District jurisdiction into a formal Medical Staff, with appropriate officers and bylaws and with staff appointments on an annual or biennial basis.

bb. Provision for a procedure for appointment and reappointment of Medical Staff as provided by the standards of The Joint Commission.

cc. Provision that the Medical Staff shall be self governing with respect to the professional work performed in hospitals and other facilities within District jurisdiction; that the Medical Staff shall meet in accordance with the minimum requirements of The Joint Commission; and that the medical records of the patients shall be the basis for such review and analysis.

dd. Provision that accurate and complete medical records be prepared and maintained for all patients.

ee. Limitations with respect to the practice of medicine and surgery in the hospitals and other facilities within District jurisdiction as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership, as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California.

Members of the Board of Directors shall also have the following duties:

aaa. Duty of Care. Directors shall exercise proper diligence in their decision-making process by acting in good faith in a manner that they reasonably believe is in the best interest of the District, and with the level of care that an ordinarily prudent person would exercise in like circumstances.

bbb. Duty of Loyalty. Directors shall discharge their duties unselfishly, in a manner designed to benefit only the District and not the Directors personally or politically, and shall disclose to the full Board of Directors situations that they believe may present a potential for conflict with the purposes of the District.

ccc. Duty of Obedience. Directors shall be faithful to the underlying purposes of the District described in Article I, section 2, herein.

If it is found, by a majority vote of all of the Board of Directors in office at that time, that a Director has violated any of his or her duties to the detriment of the District, such Director is subject to removal from office according to the procedures set forth in section 9, subdivision a, of Article IV.

The rules of the hospitals and other facilities within District jurisdiction shall, insofar as is consistent with the Local Health Care District Law and other applicable law, be in accord with and contain minimum standards not less than the rules and standards of private or voluntary hospitals. Unless specifically prohibited by law, the Board of Directors may adopt other rules which could be lawfully adopted by private or voluntary hospitals. (H&S Code §§ 32121 and 32128.)

Section 4. Compensation.

a. The Board of Directors shall serve without compensation, except that the Board of Directors, by a Resolution adopted by a majority vote of the members of the Board of Directors, may authorize the payment of not to exceed One Hundred and No/100 Dollars ($100.00) per meeting not to exceed five meetings a month as compensation to each member of the Board of Directors. (H&S Code § 32103.)

b. For purposes of this provision, "meeting" shall mean the following, to the extent permitted by applicable law: (1) any congregation of a majority of the members of the Board of Directors or of a committee or other body established by the Board of Directors, at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the Board of Directors or of the committee, if the congregation is subject to the open meeting requirements of Government Code Section 54953 and other applicable law; (2) and any other occurrences described in Government Code section 53232.1, if authorized pursuant to a written Board of Directors Policy; provided that payment of compensation shall be further subject to a member's compliance with such policies as the Board of Directors may establish. A Director is eligible for compensation under this provision for attendance at a regular or special meeting of a committee or subcommittee only if the Director is a duly-appointed member of that committee or subcommittee as of the date of attendance, or as may be authorized by Board of Directors Policy as an "occurrence" and permitted by law..

c. Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of the District as approved by the Board of Directors in accordance with applicable law, including but not limited to the provisions set forth in AB 1234, as they may be revised from time to time. (H&S Code §32103.)

Section 5. Vacancies.

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code, State of California laws and other applicable law. (H&S Code §32100.)

Section 6. Resignations.

Any member of the Board of Directors may resign at any time by giving written notice to the Board of Directors, or to the Chairperson, or to the Secretary or to the Clerk of the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein and unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

Section 7. Absences From Meetings.

The term of any member of the Board of Directors shall expire if he or she is absent from three consecutive regular meetings, or from three of any five consecutive regular meetings of the Board of Directors, and the Board of Directors by resolution declares that a vacancy exists on the Board of Directors.

MEETINGS OF DIRECTORS

Section 8. Regular Meetings.

Regular meetings of the Board of Directors of the District shall be scheduled for the last Thursday of each calendar month at a time determined by the Board of Directors at least annually, in Assembly Room 3 of the Eugene L. Geil Pavilion, Tri-City Medical Center, 4002 Vista Way, Oceanside, California. The Board of Directors may, from time to time, change the time, the day of the month of such regular meetings and the location (provided the location is within the boundaries of the District) as dictated by holiday schedules or changing circumstances. (H&S Code § 32104; Gov. Code § 54954.)

Section 9. Special Meetings.

A special meeting of the Board of Directors may be called at any time by the presiding officer of the Board of Directors or by four (4) members of the Board of Directors, by providing written notice as specified herein to each member of the Board of Directors and to each local newspaper of general circulation, radio or television station requesting notice in writing.

The notice shall be delivered by any means to effectuate actual notice, including but not limited to, personally or by mail and shall be received at least twenty-four (24) hours before the time of the meeting as specified in the notice.

The call and notice shall specify the time and place of the special meeting and the business to be transacted or discussed. No other business shall be considered at these meetings by the Board of Directors.

The written notice may be dispensed with as to any Board of Directors member who at or prior to the time the meeting convenes files with the Clerk or Secretary of the Board of Directors a written waiver of notice. The waiver may be given by telegram. The written notice may also be dispensed with as to any Board of Directors member who is actually present at the meeting at the time it convenes.

The call and notice shall be posted at least twenty-four (24) hours prior to the special meeting in a location that is freely accessible to members of the public. (Gov. Code § 54956.)

Section 10. Quorum.

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business. (H&S Code § 32106.) A quorum of the Board of Directors is the number of members that must be present in order to transact business. Members of the Board of Directors who are disqualified by law from participating in a given matter may not be counted toward a quorum for that matter. Members who are entitled to vote, but who voluntarily abstain from voting on a given matter, shall be counted toward a quorum for that matter.

Section 11. Number of Votes Required for Board of Directors Action.

In order for the Board of Directors to take action, a majority of the Directors entitled to vote on the matter and who have not abstained must vote in favor of the motion, proposal or resolution.

Section 12. Adjournment.

The Board of Directors may adjourn any regular, adjourned regular, special or adjourned special meeting to a time and place specified in the order of adjournment. Less than a quorum may so adjourn from time to time. If all members are absent from any regular or adjourned regular meeting, the Secretary or Assistant Secretary of the Board of Directors may declare the meeting adjourned to a stated time and place and he or she shall cause a written notice of the adjournment to be given in the same manner as provided for special meetings, unless such notice is waived as provided for in special meetings.

A copy of the order or notice of adjournment shall be conspicuously posted on or near the door of the place where the regular, adjourned regular, special or adjourned special meeting was held within twenty-four (24) hours after the time of adjournment.

When a regular or adjourned regular meeting is adjourned as herein provided, the resulting adjourned regular meeting is a regular meeting for all purposes. When an order of adjournment of any meeting fails to state the hour at which the adjourned meeting is to be held, it shall be held at the hour specified for regular meetings by these Bylaws. (Gov. Code § 54955.)

Section 13. Public Meetings.

All meetings of the Board of Directors shall be open and public, and all persons shall be permitted to attend any meeting of the Board of Directors, except as otherwise provided in the Ralph M. Brown Act, the Local Health Care District Law and other applicable law. (Gov. Code § 54953(a); H&S §§ 32106 and 32155.)

Section 14. Setting the Agenda.

At least seventy-two (72) hours before a regular meeting, the Board of Directors of Tri-City Healthcare District or its designee shall post an agenda containing a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session. A brief general description of an item generally need not exceed 20 words. The agenda shall specify the time and location of the regular meeting and shall be posted in a location that is freely accessible to members of the public. If requested, the agenda, shall be made available in appropriate alternative formats to persons with a disability, as required by Section 202 of the Americans with Disabilities Act of 1990 (42 U.S.C. Sec. 12132). In addition, the agenda shall include information regarding how, to whom, and when a request for disability related modification or accommodation, including auxiliary aids or services may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meetings. The agenda is developed by the Board of Directors' Chairperson, President/Chief Executive Officer and General Legal Counsel. Any other Board of Directors member has the right to place an item on the agenda through the Chairperson. In the absence of the Chairperson, the Vice Chairperson has the authority to place an item on the agenda, and in the absence of both the Chairperson and Vice Chairperson, the Secretary has the right to place an item on the agenda. In the absence of the Chairperson, Vice Chairperson, and Secretary, the President/Chief Executive Office or General Legal Counsel shall place an item on the agenda, as requested by any Board of Directors member. All requests by Board of Directors members regarding placement of an item on the agenda shall be in writing.

No action or discussion shall be undertaken on any item not appearing on the posted agenda, except that members of the Board of Directors or its staff may briefly respond to statements made or questions posed by persons exercising their public testimony rights under Government Code Section 54954.3 of the Brown Act. In addition, on their own initiative or in response to questions posed by the public, a member of the Board of Directors or its staff may ask a question for clarification, make a brief announcement, or make a brief report on his or her own activities. Furthermore, a member of the Board of Directors or the Board of Directors itself, subject to rules or procedures of the Board of Directors, may provide a reference to staff or other resources for factual information, request staff to report back to the body at a subsequent meeting concerning any matter, or take action to direct staff to place a matter of business on a future agenda.

The Board of Directors may take action on items of business not appearing on the posted agenda under any of the conditions stated in subsection (b) of Government Code Section 54954.2 or other applicable law. Prior to discussing any item pursuant to subdivision (b) of Government Code Section 54954.2, the Board of Directors shall publicly identify the item.

There must be a determination by a majority vote of the members of the Board of Directors that an emergency situation exists, as defined in Government Code Section 54956.5, as it may be revised

from time to time, or upon a determination by a two-thirds vote of the members of the Board of Directors present at the Board of Directors meeting, or, if less than two-thirds of the members are present, a unanimous vote of those members present, that there is a need to take immediate action, and that the need for action came to the attention of the Board of Directors subsequent to the agenda being posted.

Section 15. Rules of Order.

The rules contained in Robert's Rules of Order on Parliamentary Procedure shall govern the meetings of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT in all cases to which they are applicable and in which they are not inconsistent with the law of the State of California, the United States, or these Bylaws and/or policies and procedures as adopted by this governing body.

Section 16. Conflicts of Interest.

The Board of Directors of TRI-CITY HEATHCARE DISTRICT shall comply with all applicable laws regarding conflicts of interest, including but not limited to the California Political Reform Act, the provisions of the California Government Code regarding Prohibited Interests in Contracts, the California Doctrine of Incompatible Offices, as these laws may be amended from time to time.

ARTICLE IV

OFFICERS

Section 1. Officers.

The officers of the Board of Directors shall be a Chairperson, a Vice Chairperson, a Secretary, a Treasurer, an Assistant Secretary, and an Assistant Treasurer. No person shall hold more than one office. Whenever a Board of Directors officer is authorized to execute a written instrument in his or her official capacity, other than for reimbursement of expenses, the Chairperson and Secretary shall do so.

The Board of Directors has the power to prescribe the duties and powers of the District President/Chief Executive Officer, the secretary, and other officers and employees of any health care facilities of the District, to establish offices as may be appropriate and to appoint Board of Directors members or employees to those offices, and to determine the number of and appoint all officers and employees and to fix their compensation. The officers and employees shall hold their offices or positions at the pleasure of the Board of Directors. (H&S Code §§ 32100.001 and 32121(h).)

Section 2. Election of Officers.

The officers of the Board of Directors shall be chosen every calendar year by the Board of Directors at the regular December meeting. Board of Directors members who are unable to be present at the regular December meeting may attend via teleconference and vote on the election of officers provided their teleconference location meets the applicable legal requirements for participation. They shall assume office at the close of that meeting, and each officer shall hold office for one year, or until his or her successor shall be elected and qualified, or until he or she is otherwise disqualified to serve.

Section 3. Chairperson.

The Board of Directors shall elect one of their members to act as Chairperson. If at any time the Chairperson shall be unable to act, the Vice Chairperson shall take his or her place and perform his or her duties. If the Vice Chairperson shall also be unable to act, the Board of Directors may appoint some other member of the Board of Directors to do so and such person shall be vested temporarily with all the functions and duties of the office of the Chairperson.

The Chairperson, or member of the Board of Directors acting as such as above provided:

a. Shall preside over all the meetings of the Board of Directors.

b. Board of Directors Chairperson, or his or her designee, shall attend Medical Executive Committee, Joint Conference Committee meetings and other similar meetings of non-District organizations related to operations of the hospital (including those of Medical Staff committees and the hospital foundation) on behalf of the Board of Directors. Designees shall be Board of Directors members and shall at all times exclusively represent the interests of the Board of Directors. Designees may be removed at any time at the sole discretion of the Board of Directors Chairperson.

c. Shall sign as Chairperson, on behalf of the District, all instruments in writing which he or she has been specifically authorized by the Board of Directors to sign, provided that such instruments shall also be signed by the Secretary of the Board of Directors (other than for reimbursement requests).

d. Shall have, subject to the advice and control of the Board of Directors, general responsibility for management of the affairs of the District during his or her term in office. (H&S Code § 32100.001.)

Section 4. Vice Chairperson.

The Board of Directors shall elect one of their members to act as Vice Chairperson. The Vice Chairperson shall, in the event of death, absence, or other inability of the Chairperson, exercise all the powers and perform all the duties herein given to the Chairperson.

Section 5. Secretary.

The Board of Directors shall elect one of their members to act as Secretary. The Secretary of the Board of Directors shall perform ministerial duties (i.e. sign legal documents on behalf of the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. (H&S Code § 32100.001.)

Section 6. Treasurer.

The Board of Directors shall elect one of their members to act as Treasurer. The Treasurer shall be required to fulfill the duties under Health and Safety Code Section 32127; provided, however, that these duties are hereby delegated to the District's Chief Financial Officer to the extent permitted by law. (H&S Code § 32127; Gov. Code § 53600 et seq.)

Section 7. Assistant Secretary.

The Board of Directors shall elect one of their members to act as Assistant Secretary. The Assistant Secretary shall in the event of death, absence or other inability of the Secretary, exercise all the powers and perform all the duties herein given to the Secretary.

Section 8. Assistant Treasurer.

The Board of Directors shall elect one of their members to act as Assistant Treasurer. The Assistant Treasurer shall in the event of death, absence or other inability of the Treasurer, exercise all the powers and perform all the duties herein given to the Treasurer.

Section 9. Removal, Resignation or Vacancy.

a. Any officer appointed or elected by the Board of Directors may be removed from that office for failure to discharge the duties of that office, for violation of any of the policies of the Board of Directors, or for any other good cause, as determined by a majority vote of all the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

b. Any officer may resign from said office at any time by giving written notice to the Chair of the Board of Directors, the Board of Directors Secretary or to the Clerk of

the Board of Directors. Any such resignation shall take effect as of the date of the receipt of the notice or any later time specified therein, and, unless specified therein, the acceptance of such resignation shall not be necessary to make the resignation effective.

c. In the event of a vacancy in the office of the Chairperson, the Vice-Chairperson shall succeed to that office for the balance of the unexpired term of the Chairperson. In the event of a vacancy in the office of the Secretary or Treasurer, the Assistant Secretary or Treasurer, as applicable, shall succeed to that office for the balance of the unexpired term of that officer. The Board of Directors may, but is not required to elect an officer to fill the vacancy in a subordinate office.

Section 10. Determination of and Sanctions for Willful or Corrupt Misconduct in Office

The following procedure may be used, in addition to any other procedures authorized by law or policy, to determine whether a Board of Directors member has engaged in willful or corrupt misconduct in office within the meaning of Government Code section 3060.

a. Any member of the Board of Directors may present an accusation in writing to the Board of Directors against another member of the Board of Directors alleging willful or corrupt misconduct in office, together with any written materials to support the accusation. "Misconduct in office" shall be broadly construed and include any willful malfeasance, misfeasance, and/or nonfeasance in office, and shall be interpreted in a manner consistent with Government Code section 3060.

b. After consideration of the accusation, the Board of Directors members present shall then vote on the question of authorizing a formal hearing on the accusation presented. A formal contempt hearing is authorized by the Board of Directors upon the concurrence of a majority of the members present, excluding the accused who shall not have a vote.

c. Within 7 days of the authorization for a formal contempt hearing, the Board of Directors shall serve upon the accused a copy of the accusation, a statement identifying the reasons for the hearing, and a notice of the date of the hearing. The date of the hearing shall not be less than 10 days from the service of the accusation. Service shall be in person, or if that fails, by leaving a copy of the accusation taped to the entry door of the accused's last known address in plain view.

d. The accused shall appear before the Board of Directors at the time and date stated in the accusation. However, if the date chosen by the Board of Directors is unacceptable to the accused for good cause as determined by the Board of Directors, another date shall be assigned, but shall not be more than 30 days beyond the original date set by the Board of Directors.

e. The accused may be represented by counsel in preparing for and/or to be present at the hearing. The cost of such counsel shall be borne by the accused. If the accused chooses to have an attorney represent him at the hearing, he must notify the Secretary of the Board of Directors in writing of that fact at least 5 days before the hearing. The Board of Directors may have a lawyer who is not the regular Board of

Directors lawyer, present at the hearing who will conduct the presentation of the Board of Directors' case and question witnesses. Formal rules of evidence shall not apply; however, witnesses and statements shall be made under oath and documentary evidence shall be authenticated. The Board of Directors may establish reasonable time limits on the duration of the hearing. Board of Directors counsel shall not participate in any way in the preparation of the accusation or presentation of evidence, but shall advise the Board of Directors on procedural matters.

f. Five days before the scheduled hearing, each party shall submit to the Secretary of the Board of Directors a witness list and outline of anticipated evidence, either oral or written, which they intend to introduce at the hearing. Upon demand by either party, this information shall be given to the opposing party by the Board of Directors Secretary on this date. A willful failure to supply this information on a timely basis may cause it to be excluded at the hearing.

g. At the hearing, the accused may introduce any oral testimony he or she feels will be helpful to the defense. The member of the Board of Directors who presented the accusation may introduce rebuttal evidence. The of Directors shall give weight to all evidence presented. The Board of Directors shall have the power to limit or exclude evidence which is repetitive, not relevant, or has little probative value. The proceeding shall be recorded.

h. The Board of Directors shall have the burden of establishing the willful or corrupt misconduct by the accused and the burden of proof shall be by a preponderance of the evidence. The Board of Directors may introduce any evidence, oral or written testimony, the Board of Directors feels will be helpful to its case.

i. If the accused fails to appear before the Board of Directors on the specified hearing date, the hearing may be held, based upon the evidence previously provided to the accused and other relevant evidence.

j. At the conclusion of presentation of evidence, the Board of Directors shall vote whether to hold the accused in contempt. The accused shall not be present during deliberation. A determination of misconduct shall be upon the concurrence of a majority of the Board of Directors members present, excluding the accused who shall not have a vote and cannot take part in deliberations.

k. Upon the determination by the Board of Directors of misconduct by the accused, the Board of Directors shall ask if the accused wishes to make a statement to the Board of Directors. Thereafter, the Board of Directors shall excuse the accused from the hearing and move to the determination of sanctions, which may include:

1. A statement of censure, identifying the misconduct;

2. Removal of the offending Board of Directors member from membership on one or more Board of Directors committees, or, if chair of any committee, removal from that position, for a specified period, or if no period is specified, until the annual election of Board of Directors officers;

3 Removal of the offending Board of Directors member from holding any Board of Directors office or other appointment currently held;

4. A determination that no compensation shall be earned by the offending Board of Directors member for attendance at the meeting at which the contempt occurred, or for a specified period;

5. A determination that the offending Board of Directors member shall not be provided any defense or indemnity in any civil actions or proceedings arising out of or related to the member's misconduct;

6. Rendering the offending Board of Directors member ineligible to receive any advances or reimbursement of expenses to attend future conferences or meetings (except those previously-approved for which expenses have been incurred prior to the time of the finding of misconduct, for a period of time or subject to conditions specified in the motion;

7. Referral of the matter to the County Grand Jury pursuant to Government Code section 3060, including the evidence adduced during the hearing.

8. Declaring a vacancy in the office of the accused. [May require legislation]

ARTICLE V

ARTICLE V

COMMITTEES

Section 1. Committees

The Chairperson, with the concurrence of the Board of Directors, may, from time to time, appoint one or more members of the Board of Directors and other persons as necessary or appropriate, to constitute committees for the investigation, study or review of specific matters. At the time of appointing and establishing the committee(s), the Chairperson, with the concurrence of the Board of Directors, shall establish the responsibilities of the committee(s).

The Chairperson, with the approval of the majority of the Board of Directors, may, from time to time, with or without cause, remove one or more members of the Board of Directors and any other persons from membership in any standing or other committee, or may temporarily discontinue, change the functions of, or combine standing or other committees.

Any committee(s) established to deliberate issues affecting the discharge of Medical Staff responsibilities shall include Medical Staff members.

No committee shall use written ballots, whether or not secret, for any purpose in its deliberations. No committee appointed shall have any power or authority to commit the Board of Directors or the District in any manner, unless the Board of Directors, by a motion duly adopted at a meeting of the Board of Directors, has specifically authorized the committee to act for and on behalf of the District.

Any advisory committee, whether permanent or temporary, which is a legislative body as defined in the Brown Act and other applicable law, shall post agendas and have meetings open to the public as provided by law.

Notices of meetings of committees which are legislative bodies shall be made in accordance with Article IV, Section 7 of these Bylaws.

Section 2. Standing Committees

Standing committees as defined by the Brown Act are open to the public and require posting of Notice of Meetings and Agendas. The following committees are the only current standing committees of the Board of Directors:

A. Finance, Operations & Planning Committee

B. Community Healthcare Alliance Committee

C. Governance & Legislative Committee

D. Human Resources Committee

E. Professional Affairs Committee

F. Audit, Compliance & Ethics Committee

The Board of Directors shall review annually the committees, their functions, and their membership.

ARTICLE VI

MANAGEMENT OFFICIALS

Section 1. President/Chief Executive Officer.

The Board of Directors shall select and employ a hospital administrator to be known as "President/Chief Executive Officer" who, subject to such policies as may be adopted and such orders as may be issued by the Board of Directors, or by any of its committees to which it has delegated power for such action, shall have the responsibility, as well as the authority, to function as the President/Chief Executive Officer of the institution, translating the Board of Directors' policies into actual operation. Additionally, the President/Chief Executive Officer has the authority to make recommendations to the Board of Directors on policies related to the effective ongoing operations of the District. The Chief Operating Officer/Chief Nurse Executive and/or the Chief Financial Officer are granted signing authority on behalf of the Chief Executive Officer, in order to maintain day-to-day operation of the District.

Section 2. Clerk of the Board of Directors.

The Clerk of the Board of Directors shall be the Executive Assistant under the immediate supervision of the President/Chief Executive Officer. The President/Chief Executive Officer may assign other staff members as may be necessary to complete the work of the Board of Directors. The Executive Assistant shall serve as Clerk of the Board of Directors for the purposes of Elections Code section 307.

Section 3. Chief Compliance Officer .

The Chief Compliance Officer shall advise the Board of Directors and Chief Executive Officer regarding the design and implementation of the organization's ethics and compliance programs. The Chief Compliance Officer shall report directly to the Chief Executive Officer and shall be responsible to the Board of Directors to timely and periodically report to it regarding the status of the compliance programs and material legal and compliance risks and mitigation efforts.

Section 4. President/Chief Executive Officer's Evaluation.

The Board of Directors shall evaluate the President/Chief Executive Officer's performance annually. Such evaluation shall be reduced to writing, with a copy furnished to the President/Chief Executive Officer. The President/Chief Executive Officer shall have an opportunity to reply in writing to the Board of Directors in reference to such evaluation. All written communications concerning any evaluations shall be retained in the confidential files of the Board of Directors. (Gov. Code § 54957.)

ARTICLE VII

MEDICAL STAFF

Section 1. Medical Staff.

The physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in the State of California, who are permitted to practice in the hospitals and other facilities under the jurisdiction of TRI-CITY HEALTHCARE DISTRICT, shall be formed into a formal Medical Staff, in accordance with the Medical Staff Bylaws, Rules and Regulations, which have been approved by the Board of Directors of TRI-CITY HEALTHCARE DISTRICT. The Medical Staff Bylaws shall include, but not be limited to, the following provisions:

a. Appropriate officers.

b. Staff appointments on an annual or biennial basis.

c. Procedure for appointment and reappointment of Medical Staff as provided by the Standards of The Joint Commission.

d. That the Medical Staff shall meet in accordance with the minimum requirements of The Joint Commission.

The Medical Staff shall be self-governing with respect to the professional work performed in the hospital and the medical records of the patients shall be the basis for such review and analysis of the professional work of the Medical Staff. The Medical Staff members shall be responsible for preparing and maintaining accurate and complete medical records for all patients (medical records to include, but not be limited to, identification data, personal and family history, history of present illness, physician examination, special examinations, professional or working diagnosis, treatment, gross and microscopic pathological findings, progress notes, final diagnosis, condition on discharge and such other matters as the Medical Staff shall determine or as may be required by applicable law). The practice of medicine and surgery in the hospitals and other facilities under the jurisdiction of the District shall be within the limitations as the Board of Directors may find to be in the best interests of the public health and welfare, including appropriate provision for proof of ability to respond in damages by applicants for staff membership as long as no duly licensed physician and surgeon is excluded from staff membership solely because he or she is licensed by the Osteopathic Medical Board of California. The Medical Staff shall be responsible for the development, adoption and annual review of the Medical Staff Bylaws and Rules and Regulations that are consistent with District policy and with any applicable law. The Medical Staff are subject to, and effective upon, appointment and reappointment by the Board of Directors in accordance with the standards ofThe Joint Commission (H&S Code § 32128.)

The Tri-City Healthcare District shall maintain a Quality Assurance/Performance Improvement ("QA/PI") Program developed by a committee composed of at least five (5) physicians who are members of the Medical Staff and one (1) clerical staff member. The QA/PI Program shall be implemented by the QA/PI Committee, and shall be a data-driven, quality assessment and performance improvement program, implemented and maintained on a hospital-wide basis, in compliance with the requirements of Section 482.21 of Title 42 of the Code of Federal Regulations, and other applicable law, as it may be amended from time to time.

Section 2. Medical Staff Membership.

Membership on the Medical Staff is a privilege, not a right, which shall be extended only to physicians, surgeons, podiatrists, dentists, and allied health professionals, licensed to practice in this State whose education, training, experience, demonstrated competence, references and professional ethics, assures, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care. Each applicant and member shall agree to abide by the District Bylaws, Medical Staff Bylaws and Rules and Regulations of the District, and applicable law. The word "Physician" when used hereafter in this Article, shall be deemed to include physicians, surgeons, dentists, and podiatrists. (H&S Code § 32128.)

Section 3. Exclusion from the Medical Staff.

a. The Board of Directors shall have the power to exclude from Medical Staff membership, to deny reappointment to the Medical Staff, or to restrict the privileges of any physician, whether a general practitioner or specialist, in any hospital operated by the District, who has not exhibited that standard of education, training, experience, and demonstrated competence, references and professional ethics which will assure, in the judgment of the Board of Directors, that any patient admitted to or treated in the hospitals and other facilities under District jurisdiction will be given high quality professional care.

b. In the case of both general practitioners and specialists, the medical resources available in the field of his or her practice shall be considered in determining the skill and care required. No physician shall be entitled to membership on the Medical Staff, or to the enjoyment or particular privileges, merely by virtue of the fact that he or she is duly licensed to practice medicine or surgery in this or any other state, or that he or she is a member of some professional organization, or that he or she, in the past or presently, has such privileges at another hospital. The burden shall be upon the physician making an initial application for membership to establish that he or she is professionally competent and ethical. (H&S Code §§ 32128 and 32150; B&P Code § 809.3.)

Section 4. Hospital Rules.

The Bylaws of the Medical Staff shall set forth the procedure by which eligibility for Medical Staff membership and establishment of professional privileges shall be determined. Such Bylaws shall provide that the Medical Staff or a committee or committees thereof, shall study the qualifications of all applicants in the establishment of professional privileges, and shall submit to the Board of Directors recommendations thereon. Such recommendations shall be considered by the Board of Directors, but shall not be binding upon the Board of Directors. The Medical Staff shall be responsible for a process or processes designed to assure that individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services and that the quality of patient care services provided by these individuals is reviewed as a part of the District's quality assurance programs. (H&S Code § 32150.)

Section 5. Hearings and Appeals.

The Board of Directors hereby incorporates by reference the provisions of the Medical Staff Bylaws relating to hearing procedures and appeals regarding the professional privileges of any member of, or applicant for membership on, the Medical Staff, as those Bylaws may be amended from time to time, subject to applicable law. These provisions are presently outlined in the relevant sections of the Medical Staff Bylaws.

ARTICLE VIII

MISCELLANEOUS

Section 1. Title to Property.

The title to all property of the District shall be vested in the District, and the signature of any officers of the Board of Directors, authorized at any meeting of the Board of Directors, shall constitute the proper authority for the purchase or sale of property or for the investment or other disposal of funds which are subject to the control of the District. (H&S Code §§ 32121(c) and 32123.)

Section 2. Seal.

The Board of Directors shall have the power to adopt a form of Corporate Seal, and to alter it at its pleasure. (H&S Code § 32121(a).)

Section 3. Amendment.

These Bylaws may be altered, amended, repealed, added to or deleted, by a majority vote of all of the Board of Directors in office at that time, at any regular or special meeting of the Board of Directors.

Section 4. Annual Review of Bylaws.

The Board of Directors shall review the Bylaws annually and make any necessary changes that are necessary to be consistent with District policy, any applicable laws or other rules and regulations connected with operation of a hospital or other facility within District jurisdiction.

Section 5. Board of Directors' Evaluation Policy.

The Board of Directors shall establish a written policy and procedure for evaluation and review of the Board of Directors' performance as a group. This written copy of the Board of Directors' policy and procedures shall be reviewed by the Board of Directors, the President/Chief Executive Officer and the District Legal Counsel for the Board of Directors.

Section 6. Affiliated Organizations.

a. Auxiliary Organizations. The Board of Directors may authorize the formation of auxiliary organizations to assist in the fulfillment of the purposes of the District. Each such organization shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

b. Foundations. The Board of Directors may authorize the formation of non-profit public benefit corporations, under applicable law, to assist in the fulfillment of the purposes of the District. Each such corporation shall establish its bylaws, rules, and regulations, which shall be subject to Board of Directors approval and which shall not be inconsistent with these bylaws or the policies of the Board of Directors.

CODE FOR LEGISLATIVE AUTHORITY

H&S	-	The Local Health Care District Law, Health and Safety Code Section 32000 et seq., State of California
Elections Code	-	Uniform District Election Law, Elections Code, State of California
Government Code	-	Government Code, State of California
B&P	-	Business and Professions Code, State of California

This amendment to the TRI-CITY HEALTHCARE DISTRICT Bylaws is approved this ~~30~~28th day of ~~June~~September, 2017.

James J. Dagostino Date
Chairperson

ATTEST:

Laura E. Mitchell Date
Secretary

Tri-City Medical Center
Audit, Compliance & Ethics Committee
September 21, 2017
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Leigh Anne Grass; 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; Kapua Conley, COO; Scott Livingstone, Interim CCO; Carlos Cruz, CCO, Susan Bond, Director, Legal Services
Others Present:,	Greg Moser, General Counsel; Teri Donnellan, Executive Assistant; Stacy Stelzriede, Partner, Moss Adams; Annie Norviel, Senior Manager, Moss Adams; Charlene Carty, Director, Finance; Anh Nguyen, Controller; Sharon Schultz, CNE; Kristy Larkin, Director of Compliance, Audit & Monitoring
Absent:	

	Discussion	**Action Recommendations/ Conclusions**	**Person(s) Responsible**
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock. Chairman Schallock introduced Carlos Cruz, Chief Compliance Officer, Kristy Larkin, Director of Compliance, Audit & Monitoring and Susan Bond, Director, Legal Services. Mr. Cruz, Ms. Bond and Ms. Larkin each provided a summary of their background and experience. Community members introduced themselves to Mr. Cruz, Ms. Bond and Ms. Larkin.		
2. Approval of Agenda	**It was moved by Leslie Schwartz and seconded by Director Dagostino to approve the agenda as presented. The motion passed unanimously.** Chairman Schallock noted there are no Closed Session agenda items for discussion.	**Agenda approved.**	
3. Comments by members of the public and committee members on any item of interest to the	There were no public comments.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
public before Committee's consideration of the item			
4. Ratification of minutes – July 20, 2017	**It was moved by Director Dagostino and seconded by Ms. Kathryn Fitzwilliam to approve the minutes as presented. The motion passed unanimously.**	**Minutes ratified.**	
5. Old Business	None		
6. New Business A) Fiscal 2017 Financial Statement Audit Status – Moss Adams	Ms. Stacy Stelzeride, Engagement Reviewer stated she and Ms. Norviel are here today to present the results of the FY2017 Financial Audit. Ms. Stelzeride stated since the auditors last met with the Committee they identified that the HUD agreement required an additional single audit. The engagement letter was modified to incorporate this report. The single audit will be combined with the financial audit to meet the requirements of HUD. Ms. Stelzeride stated the auditors also performed the following non-attest services including: ➢ Assist in the drafting of the Schedules of Expenditures of Federal Awards ➢ Completion of the Auditee portion of the Data Collection Form ➢ Feasibility study – HUD financing Ms. Stelzeride stated they will issue an unmodified opinion which reflects the Consolidated Financial Statements are presented fairly and in accordance with US Generally Accepted Accounting Principles. Ms. Stelzeride stated two additional opinions were needed regarding the single audit. The auditors found no financial reporting findings however Compliance Finding indicated that quarterly reports and the budget were not submitted timely with respect to the HUD loan program. Ms. Stelzeride stated this is easily remedied and nothing that HUD will be	**Recommendation to be sent to the Board of Directors to accept the FY2017 Financial Statement Audit and the Single Audit in accordance with the Uniform Guidance and Consolidated Financial Statements as presented; item to appear on Board agenda and included in agenda packet.**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	concerned about. She stated management has a plan in place to ensure these items are submitted timely. Ms. Annie Norviel stated significant management estimates impacted the consolidated financial statements including the following: Patient accounts receivable allowances; accrual for workers' compensation and medical malpractice liabilities; accruals for third party settlements. Auditors deemed them to be reasonable. Ms. Norviel and Ms. Stelzeride reviewed the following notes in detail: ➢ Note 3 – Patient Service Revenue, Third Party Reimbursement Programs and Non-Operating Revenue ➢ Note 7 – Short-term Debt ➢ Note 8 – Long-term Debt ➢ Note 13 – Commitments and Contingencies ➢ Note 14 – Subsequent Events Ms. Stelzeride reported the following: ➢ The disclosures in the financial statements are clear and consistent. ➢ There were no proposed or corrected or uncorrected audit adjustments. ➢ No material weakness was identified. ➢ There were no significant deficiencies. There is nothing to communicate other than the finding noted related to the Single Audit. ➢ No significant difficulties were encountered during the audit of the District's financial statements. ➢ There were no disagreements with management.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	➢ The auditors are not aware of any instances of fraud or noncompliance with laws and regulations. There was extensive discussion regarding the Medical Office Building proceeding. Ms. Stelzeride stated contingencies related to the MOB matter have been disclosed in the consolidated financial statements as of and for the year ended June 30, 2017. Ms. Stelzeride explained the change financially from last year is the $12.2 million that was deposited with the State Treasurer. She stated that amount has been reflected and recorded as an asset. Director Grass questioned if there are other judgments in the MAC matter that have not been accounted for. Mr. Moser stated there is a $2.9 million judgment for bad faith however that is pending appeal. Mr. Dietlin referred the committee to Note 13 which discloses the judgement. Mr. Dietlin stated there are many scenarios possible in the MAC appeal. Ms. Stelzeride stated she is confident that matters related to the MAC matter have been disclosed and are recorded appropriately. Mr. Dietlin questioned what percentage of Moss Adams' clients has no adjustments. Ms. Stelzeride stated very few companies have no adjustments and Tri-City should be proud of the fact that we have had no adjustments. Discussion was held regarding how Tri-City compares to industry standards. Ms. Stelzeride stated she would need to find benchmarks for district hospitals for a fair comparison. Ms. Fitzwilliam commented on audits for patch management. Mr. Cruz stated the district performs security risk assessments routinely. Mr. Rivas stated a position has been budgeted for an individual to perform cyber security as their sole function. *Ms. Kathy Topp joined the meeting at 9:03.*		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Mr. Schwartz requested clarification on the two audit documents. Ms. Stelzeride explained the second document is drafted in accordance with the Uniform Guidance for Federal Awards related to the HUD loan. She stated that when the audit is issued the two audits will be combined into one report. Ms. Stelzeride stated the Management Representation Letter is available upon request. The second part of the presentation reviewed financial ratios and metrics including the following; ➢ Cash on Hand - 71 ➢ Current Ratio - 1.70 ➢ Days in Accounts Receivable - 51 ➢ Debt Capitalization - 49% ➢ EBITDA % of Operating Income - 5.6% Director Grass questioned if there is a requirement regarding the number of days for cash on hand. Mr. Dietlin stated there is no regulatory requirement however lenders may have specific requirements. **It was moved by Mr. Schwartz to recommend the Board accept the FY 2017 Financial Statement Audit and the Single Audit in accordance with the Uniform Guidance and Consolidated Financial Statements. Director Dagostino seconded the motion. The motion passed unanimously.** *Ms. Stelzeride, Ms. Norviel, Ms. Carty and Ms. Nguyen left the meeting at 9:30 a.m.*		
B) Administrative Policies & Procedures: 1) Employee Response to	Ms. Topp Kathy stated minor revisions were made to the Employee Response to Government Investigation policy to reflect processes we have in place. Ms. Topp noted the policy is being brought forward to this Committee rather than	**Recommendation to be sent to the Board of Directors to approve Employee Response to**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
Government Investigation	the Professional Affairs Committee due to the fact that all compliance polices (500 series) now come to the Audit, Compliance & Ethics Committee. It was suggested that the word "either" be added to Section C. 2 immediately following the word notify. Mr. Schwartz requested clarification on Section C. 4. related to the destruction of documents. Mr. Livingstone stated there is a separate policy that outlines destruction dates and processes for documents. Ms. Topp suggested the policy related to destruction of documents be noted as a reference on the policy. Discussion was held regarding whether Section C. 6. and 7 should be reversed. After discussion It was determined these sections should stand as written. **It was moved by Director Dagostino and seconded by Mr. Schwartz to recommend approval of the Employee Response to Government Investigation Policy as amended. The motion passed unanimously.**	**Government Investigation to the Board; item to be placed on agenda and included in agenda packet.**	
2) Advanced Beneficiary Notice	Ms. Topp stated the Advanced Beneficiary Notice policy was updated to be consistent with current practice. It was recommended that "Affected departments include" be added to Section B. 1. at the beginning of first sentence. It was moved by Director Dagostino and seconded by Ms. Fitzwilliam to recommend approval of Advanced Beneficiary Notice policy to the Board of Directors as amended. The motion passed unanimously. *Ms. Topp left the meeting at 9:43 a.m.*	**Recommendation to be sent to the Board of Directors to approve Advanced Beneficiary Notice policy as amended; item to be placed on agenda and included in agenda packet.**	Ms. Donnellan
8. Comments from Committee Members	Chairman Schallock reported the Board participated in a workshop last week and one item of discussion related to the Board Committee's structure and how management time is utilized on those committees. Committees have been asked to evaluate their membership and meeting frequency.	Information only.	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Chairman Schallock stated he anticipates the committee will have a better structure in place by the first of the year. Ms. Fitzwilliam stated she hoped the community members will be able to continue to contribute to the committee. Chairman Schallock assured Ms. Fitzwilliam that the committee values the expertise that community members provide and looks forward to their continued participation. Chairman Schallock briefly reviewed Ms. Larkin's role related to internal audits. Mr. Livingstone stated he is confident we have someone in house that is very competent. Chairman Schallock expressed his appreciation to Mr. Livingstone for his time and talents in the interim leadership role of Chief Compliance Officer.		
9. Committee Openings	Chairman Schallock reported Mr. Jack Cumming's term on the committee has expired. There is currently one opening on the committee.	Information only.	
10. Date of Next Meeting	Chairman Schallock stated the Committee's next meeting will be held on October 19, 2017.	**The committee's next meeting is scheduled for October 19, 2017.**	
11. Adjournment	Chairman Schallock adjourned the meeting at 9:55 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE
September 21, 2017

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Employee Response to Government Investigation	502	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
2. Advanced Beneficiary Notice	503	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions

Tri-City Medical Center
Oceanside, California

Administrative Policy
Compliance

ISSUE DATE: 02/99 **SUBJECT:** Employee Response to Government Investigation

REVISION DATE: 04/03, 12/05 **POLICY NUMBER:** 8610-502

Department Approval:	**~~10/15~~07/17**
Administrative Policies & Procedures Committee Approval:	**~~10/15~~07/17**
~~**Operations Team Committee Approval:**~~	~~**05/09**~~
~~**Professional Affairs Committee Approval:**~~	~~**06/09**~~
Organizational Compliance Committee Approval:	**08/17**
Audit and Compliance Committee Approval:	**09/17**
Board of Directors Approval:	**06/09**

A. **PURPOSE:**

1. To establish a mechanism for an orderly response to government investigations that enables Tri- City ~~Medical Center~~**Healthcare District** (TC**HD**~~MC~~) employees to appropriately cooperate with the investigation and to protect their interest and the interests of the hospital.

B. **DEFINITION:**

1. For the purposes of this policy, "designated employee" means the individual(s) (**Director of** Risk **Management**~~Manager~~, **Chief** Compliance Officer, **Director of Regulatory Compliance;** and/or Administrator) assigned to assist with the investigation.

C. **POLICY:**

1. TC**HD**~~MC~~ will cooperate with any appropriately authorized government investigation or audit; however, TC**HD**~~MC~~ will assert all protections afforded it by law during any investigation or audit.
2. Any employee contacted by a government investigator for any reason should immediately notify **either** the **Director of** Risk **Management**~~Manager~~, **Chief** Compliance Officer, or Administrator on call. The designated employee will notify the ~~Senior Claims Supervisor at Program BETA~~**District's Insurance Broker/Carriers** and legal counsel, if appropriate.
3. Employees must not discuss ~~the search warrant~~**any documents referenced or provided by the investigator** and related matters with anyone other than legal counsel, **either** the **Chief** Compliance Officer, **Director of** Risk **Management**~~Manager~~, or Administration. ~~If there are~~**All** media inquiries~~,~~ **should be routed to** TC**HD's**~~MC personnel should respond only after legal counsel and Administration have reviewed any proposed statement~~ **marketing department.**
4. TC**HD**~~MC~~ employees shall not alter, remove, or destroy permanent documents or records. All records are subject to state or ~~national~~ **federal** retention guidelines and may be disposed of only according to these guidelines. Once there has been notice of an investigation, the destruction portion of any policy on record retention is suspended.
5. Government investigators may arrive unannounced at TC**HD**~~MC~~ or at the homes of present or former employees. There is no obligation to consent to an interview request by government investigators; however, an employee may volunteer to participate. The employee may request that the interview be conducted during normal working hours on-site at TC**HD**~~MC~~ or another location.
6. When an interview or search is requested, the employee should be courteous in requesting the following information:
   a. The name, agency affiliation, business telephone number, and address of all

investigators.

b. The name of the "agent in charge".

c. The reason for the visit.

7. The employee should then immediately inform the **Director of** Risk **Management**~~Manager~~, the **Chief** Compliance Officer, or Administrator on Call.

D. RELATED DOCUMENT(S):

~~7.~~1. **Board of Directors: 008 Records Retention and Destruction Policy**

Tri-City Medical Center
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 02/99 **SUBJECT:** Advanced Beneficiary Notice

REVISION DATE: 11/02; 12/02, 12/03, 10/05, 11/08 02/11; 09/13 **POLICY NUMBER:** 8610-503

Department Approval:	**03/17**
Administrative Policies and Procedures Committee Approval:	**~~09/13~~04/17**
Organization Compliance Committee Approval:	**08/17**
~~**Professional Affairs Committee Approval:**~~	~~**10/13**~~
Audit, Compliance and Ethics Committee Approval:	**09/17**
Board of Directors Approval:	**10/13**

A. **PURPOSE:**

~~1. To ensure that an Advance Beneficiary Notification (ABN) is obtained from Medicare Beneficiaries when tests, medications, or services are provided by Tri-City Healthcare District. (TCHD).~~

~~2.~~**1.** To insure an Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries when Tri-City Healthcare District **(TCHD)** wishes to bill for outpatient tests and services that may not be covered by CMS.

~~3.~~**2.** TCHD will conduct patient care and all other business operations in a legal and ethical manner. Employees are expected to observe federal, state and local laws. TCHD will not tolerate fraud, waste and/or abuse in any manner, and employees are expected to adhere to all guidelines and regulations governing Medicare and other Federal and State funded healthcare programs.

~~B. DEFINITIONS:~~

~~1. For purposes of this policy and procedure, the term "services" is meant to include tests, medications, or services provided by Tri-City Healthcare District.~~

~~C.~~**B.** **OVERVIEW:**

1. **Effective departments include:** Admitting Services (Scheduling and Registration), Compliance, Case Management, Medical Staff, Physician Office Staff, Laboratory, Patient Accounts, Ancillary Departments.
2. Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary before Part B services are furnished when TCHD believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act) and TCHD wishes to bill the patient for the provided services. The ABN gives the beneficiary an idea of why TCHD is predicting the Medicare denial. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.
3. If TCHD expects payment for the services to be denied by Medicare, TCHD employees will advise the beneficiary before services are furnished that, in our opinion, the beneficiary will be personally and fully responsible for the payment.
4. "Personally and fully responsible for payment": This means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other federal or non-federal payment source. TCHD must issue notices each time, and as soon as, we believe Medicare payment will be denied due to a medical necessity reason. TCHD is not required to give ABN's to beneficiaries for items or

tests that are statutorily excluded from Medicare payment, such as oral medications or routine screening tests, which fall under the routine physical exclusion (i.e., under §1862(a)(7) of the act.) If TCHD does not provide a proper ABN in situations where one is required, TCHD will be held liable for the loss of payment if Medicare denies the claim.

a. Notation: An ~~Advance Beneficiary Notice~~**ABN** must be obtained for initial standing orders (for extended course of treatment) that contain tests that may be covered. However, it is not necessary to obtain a new ABN each time the test is performed in accordance with the standing order.
b. Routine use of the ~~Advance Beneficiary Notice~~**ABN** is prohibited. There must be a specific reason to believe Medicare will determine that the test ordered may not be considered reasonable and necessary.

5. An ~~Advance Beneficiary Notice~~**ABN** must be obtained when one or more of the following circumstances exist when TCHD wishes to bill the patient for the provided services:
   a. The test for a routine exam or screening not covered by Medicare.
   b. The test in for investigative or research use only.
   c. The diagnosis provided may not or does not meet medical necessity requirements.
   d. No diagnosis provided.
   e. The test may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
   f. The test has not been approved by the Food and Drug Administration.
   g. For those services which Medicare excludes from coverage under Part A or Part B (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, personal comfort items, etc.) an ABN may be obtained noting the appropriate reason of non-coverage.
   h. Patients must be notified well enough in advance of receiving a medical service so the patient can make a rational, informed decision.
6. The ABN will clearly identify the following:
   a. Description of service(s) that may be denied, including procedure name, price, and CPT/HCPC code if available
   b. Reason why the service may be denied
   c. Patient's name
   d. Patient's Medicare number
   e. Patient's or guarantor's signature and date
   f. Witness signature and date

~~D.~~C. DEMAND BILL:

1. A claim must always be sent for an initial determination on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare standards. Enter an occurrence code 32 on the UB-~~02~~ **04** in one of the fields numbered 32 through 35. It is the occurrence code that indicates that an ABN has been issued. A condition code of 20 must be entered in one of the fields numbered 24 through 30 to indicate Tri-City Healthcare District felt the services would probably be non-covered or denied by Medicare.

~~E. POLICY:~~

~~1. Medicare will only pay for services that it determines are reasonable and necessary. An ABN must be obtained when ordered tests, medications, or services are or may be non-covered.~~
~~2. Routine use of the ABN is prohibited. There must be a specific reason to believe that Medicare will determine that the service ordered may not be reasonable and necessary.~~
~~3. The patient or guardian must be instructed on the purpose and implications of the form.~~
~~4. The following guidelines must be followed to insure that an ABN is obtained in accordance with Medicare requirements.~~
~~a. An ABN must be obtained when one or more of the following circumstances exist:~~
~~i. Diagnostic information may or does not meet medical necessity requirements for the service ordered~~

~~ii. The service may be paid for a limited number of times within a specified time period, and the visit may exceed the limit.~~
~~iii. The service has not been approved by the Food and Drug Administration.~~

~~5. An ABN must be accurately and legibly completed (using the most current Centers for Medicare & Medicaid Services (CMS) Advance Beneficiary Notification form) and identify the following:~~
~~a. Description of the service(s) that may be denied, including the name of the procedure and CPT/HCPC code.~~
~~b. Reason the service may be denied~~
~~c. Patient's name~~
~~d. Patient's Medicare number~~
~~e. Patient or guarantor's signature and date~~
~~f. Witness signature and date~~
~~6. The patient has two choices when signing the ABN:~~
~~a. 1To obtain the service and agree to be responsible for payment should Medicare deny payment, or~~
~~b. Refuse to be responsible for payment and not obtain the service.~~
~~7. Should the beneficiary demand the service and refuse to either pay or sign the ABN form, a second employee witness shall sign the ABN form and add a note that the beneficiary refused to sign. Then the service will be provided and should Medicare payment be denied, the beneficiary would be responsible for payment.~~
~~8. If the physician initiates the ABN, the physician's office will keep a copy for the office file. If the ABN is initiated by TCHD, a copy must be kept with the patient's financial records according to financial record retention guidelines.~~
~~9. Distribute the signed ABN as follows: one copy to the patient, one copy to the registration office and the original to the business office to be kept with the patient's financial record.~~

~~F.~~D. PROCEDURE:

1. Employees entering the computerized order for outpatient tests and performing registration must review the physician's diagnosis, when processing every outpatient Medicare order.
2. If the patient presents with a completed ~~Advance Beneficiary Notice~~**ABN** from the physician's office, proceed with performing the ordered tests. A copy of the ABN must be made and kept with the patient's order
3. If the patient presents with no ~~Advance Beneficiary Notice~~**ABN** and the diagnosis provided does not meet Medical Necessity Guidelines for the test(s) being ordered, registration staff must complete an ~~Advance Beneficiary Notice~~**ABN**.
4. Instruct the patient on the purpose of the form and ask patient or guardian to sign one of two options: 1) agree to pay for service(s), which may be denied, and therefore obtain the service(s), or (2) deny responsibility and do not obtain the service(s). If the patient or guardian wishes to discuss the situation with their physician or a nurse, the registration employee will either contact the physician or a nurse in a timely manner to discuss the situation so the beneficiary may make an informed decision.
5. In the case in which the Beneficiary demands the service(s) and refuses to pay or sign the ABN form, then a second employee witness should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.
6. If the patient denies payment responsibilities and declines the test(s), then perform only those tests that meet the Medical Necessity Guidelines. It is the patient's responsibility to inform the ordering physician that services were not performed. If the patient agrees to pay for the service(s) then perform all tests ordered.
7. The signed ABN form should be distributed as follows: give the back copy to the patient, retain the middle copy at physician's office or registration office, and file the original copy with the physician's order.

~~G.~~E. REFERENCES:

1. Medicare Carrier's Manual 7300.5, Part III (HCFA Publication 14-3) 3730
2. CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

~~H.~~F. ATTACHMENTS:

1. TCHD Advanced Beneficiary ~~notice~~**Notice English– Sample**
2. **TCHD Advanced Beneficiary Notice Spanish- Sample**

TCHD Advanced Beneficiary Notice English- Sample

(A) Notifier:
(B) Patient Name: **(C) Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

Affix Patient Label

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

ADVANCE BENEFICIARY NOTICE
OF NON COVERAGE

8560-1021
(Rev. 12/11)

TCHD Advanced Beneficiary Notice Spanish - Sample

A. Notificante:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga D._____ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados.
Prevemos que Medicare no pagará D. _____ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado:

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir **D.** _____ mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. Opciones: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

❑ **OPCIÓN 1.** Quiero D. _____ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.
❑ **OPCIÓN 2.** Quiero D. _____ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.
No tengo derecho a apelar si no se le cobra a Medicare.
❑ **OPCIÓN 3.** No quiero D. _____ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

De conformidad con la Ley de reducción de los trámites burocráticos de 1995, nadie estará obligado a responder en todo pedido para recabar información a menos que se identifique con un número de control OMB válido. El número de control OMB válido para esta recolección de información es 0938-0566. El tiempo necesario para completar esta solicitud de información se calcula, en promedio, 7 minutos por respuesta, incluido el tiempo para revisar las instrucciones, buscar en fuentes de datos existentes, recabar los datos necesarios y llenar y revisar los datos recogidos. Si tiene comentarios sobre la precisión del cálculo del tiempo o sugerencias para mejorar el presente formulario, sírvase escribir a: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Formulario CMS-R-131 (03/11) Formulario aprobado OMB Nº 0938-0566

Affix Patient Label

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

6560-1022
(Rev. 12/11)

ADVANCE BENEFICIARY NOTICE OF NON COVERAGE (SPANISH)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

August 31, 2017 – 1:30 o'clock p.m.
Classroom 6 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on August 31, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry 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
Susan Bond, Director of Legal Services
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1 The Board Chairman, Director Dagostino called the meeting to order at 1:30 p.m. in Classroom 6 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2 Approval of Agenda

It was moved by Director Kellett to approve the agenda as presented. Director Mitchell seconded the motion. The motion passed unanimously (7-0).

3 Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the August 31, 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 August 31, 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; two Reports 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 Schallock 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 3:45 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 J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operations Officer
Ray Rivas, Acting Chief Financial Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Scott Livingstone, Interim Chief Compliance Officer
Susan Bond, Director of Legal Services
Greg Moser, General Legal Counsel
Victor Souza, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9 Chairman Dagostino reported no action was taken in open session.

10 Director Nygaard led the Pledge of Allegiance.

11 Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

12 Introduction –

Susan Bond, Director of Legal Services

Mr. Steve Dietlin, CEO introduced new Director of Legal Services, Ms. Susan Bond. Ms. Braun provided a brief summary of her background and experience.

13 Community Update

Presentation on the da Vinci XI

Ms. Mary Diamond, Senior Director of Nursing presented a PowerPoint presentation on the da Vinci Robot with Table Motion. She stated Tri-City is the first hospital in North County with integrated Table Motion. Ms. Diamond stated the benefits to the patient include a shorter hospital stay, decreased complications, less pain, less blood loss and a quicker return to normal activity. The benefits to the hospital include a lower total cost to treat and lower likelihood of re-admission to the hospital. Additionally, patients and surgeons seek out hospitals that support strong da Vinci programs. Ms. Diamond stated the new da Vinci Xi has a revolutionary anatomical access, crystal clear 3D-HD vision and a platform for advanced technologies.

Ms. Diamond introduced two physicians that have been instrumental in helping to start and promote our da Vinci program, Dr. Bradley Frasier, a Urology surgeon and Dr. Mohammed Jamshidi, a General Vascular Surgeon who provided a demonstration of what the robot can do. Drs. Frasier and Jamshidi expressed their appreciation to the Board and Administration for purchasing this state of the art technology. Dr. Frasier commented that it is a "game changer" for Urologic surgery; for the patient it is minimally painful, minimally invasive, results in lower blood loss, shorter hospital stays and faster recoveries. Dr. Jamshidi stated the da Vinci XI is a top of the line product. He described a single port gallbladder surgery utilizing the robot in which a very small incision (less than an inch) is made to remove the gallbladder.

Director Schallock commented that he saw Dr. Fierer last night on television at the Oceanside Boys and Girls Club demonstrating the robot to the children who appeared very impressed and excited with the opportunity to see this piece of equipment.

Ms. Diamond also introduced the champion in nursing to drive this new technology - Tessa Marie Watkins.

Ms. Watkins expressed her appreciation to the Board and everyone who was instrumental in upgrading our robotic system. She stated it is very intuitive and affectionately known by surgery as Trixie.

Chairman Dagostino expressed his appreciation to today's presenters. He stated the robot is a benefit to our patients and expressed his appreciation to the physicians for utilizing this state of art of equipment.

b) AHA Heart Walk – David Bennett, Chief Marketing Officer

Mr. David Bennett, Chief Marketing Officer formally invited the Board to form a walking team for our September 30th American Heart Association heart walk in which Mr. Dietlin is the Chair of the walk. Mr. Bennett stated that in anticipation of their willingness to walk, shirts were made for Board Members and he

encouraged the Board to develop a name for their walking team. Mr. Bennett stated we have 31 walking teams here at Tri-City with almost 400 members and over 500 members walking from the Wellness Center. He stated it is his hope that there will be well over 2,000 walkers on September 30th.

Mr. Bennett introduced Ms. Jennifer Sobotka of the American Heart Association. Ms. Sobotka expressed her appreciation to the Board and Mr. Dietlin for their leadership and support of this partnership. She stated she is thoroughly enjoining this collaboration and partnership and also recognized the Marketing team who has been phenomenal to work with.

Ms. Sobotka reiterated that the goal is to have 2,000 walkers on September 30th for this inaugural event and she feels quite confident that we are going to surpass that goal. She noted we are in the home stretch and the final 30 days is when we typically see the biggest uptake in registration and excitement and enthusiasm. Ms. Sobotka stated the Chambers in this area have also been wonderful in getting the word out as well. In closing, Ms. Sobotka stated this is more than just the walk; it is about our partnership and collaboration of all the things we are going to do together in this community.

Director Nygaard invited Ms. Sobotka to come and speak to the CHAC committee in September and tell them about the walk. Ms. Sobotka stated if there are other groups you would like us to reach out to they would love to be there.

No action taken.

Chairman Dagostino requested the Board's consent to reorder the agenda to give Mr. Johnson sufficient time for the Public Hearing portion of the meeting.

17. New Business

a. Presentation by National Demographic Corporation, Douglas Johnson, President, relative to redistricting

Chairman Dagostino read into the record a brief statement outlining the process and protocol for today's public hearing.

Mr. Douglas Johnson, President of National Demographics Corporation provided a PowerPoint presentation on Tri-City Healthcare's 2017 Districting. Mr. Johnson stated this is a change in the election system to by-zone election of the seven Board members. Mr. Johnson emphasized the change impacts elections only. All votes continue to require a majority of the Board and Board members have no special authority or power over issues in their zone. Mr. Johnson explained that this change in process is governed by Elections Code Section 10010 and Safety Code 32100.1. Mr. Johnson outlined the proposed Timeline as follows:

- August 31 – 1st hearing; gather input on the composition of zones
- September 28 – 2nd hearing; gather public input on the composition of zones
- No later than October 19th – Draft maps released
- October 26th – 3rd hearing; public input on draft maps and election sequencing
- November 9th – 4th hearing; public input on draft maps and election sequencing; selection of preferred maps: 1 with annexation, 1 without
- TBD – LAFCO decision

- By early May – Board adopts Resolution with appropriate map
- November 2018 – first by-zone elections in three zones
- November 2020 – First by-zone elections in remaining four zones

Mr. Johnson further explained that three seats are up for election in 2018 so three zones will hold elections; in 2020 four of the seats are up for election so the other four zones will hold elections at that time. For two years the Board will have three members that are elected by zone and four who are still finishing the last two years of their at large term. He stated that is standard practice and how every jurisdiction does this.

Mr. Johnson emphasized that the map drawing is a parallel process in which two maps will be drawn, one with the annexation/deannexation and one with the current district boundaries. Mr. Johnson stated these lines will only be used for one election due to the census data that will come out in 2021. At that time maps will be redrawn to reflect population shifts.

Mr. Johnson explained the other two requirements that we have to comply with are the California Voting Rights Act which defines a protected class of voters such as Latinos, Asian Americans, African Americans or Native Americans. He noted lines cannot be drawn that would dilute the protected classes voting strength.

The second requirement is no racial gerrymandering. If a neighborhood is heavily populated by Latinos or Asian Americans, for example, then we want to keep that neighborhood together.

Mr. Johnson stated a number of maps will be drawn that comply with those rules and maps are then chosen based on traditional principles which are goals, rather than requirements. He stated it is important to respect communities of interest and zones to be compact and contiguous. Another lesser known criteria is the traditional principle, respect for the voters' wishes. Essentially, to the degree possible, we want the voters to get to decide which Board members have earned re-election and an attempt is made to avoid putting Board members in the same zones. Mr. Johnson clarified the purpose is not to throw the current Board out but let the voters decide.

Other factors that are taken into consideration when drawing the maps are total population and citizen voting age population which is a measure of voting strength. In addition there is other data that traditionally defines communities such as age, income and education levels, apartment residents versus single family home residents and owner occupied housing versus rental occupied housing.

Mr. Johnson stated that using the borders currently in please, each of the seven zones would have approximately 49,000 residents. It is important that residents indicate what their community of interest is and whether they want that community kept together or divided.

Following Mr. Johnson's presentation, Chairman Dagostino reiterated the ground rules for the public hearing. General Counsel, Ms. Ochoa stated it is at the Board's discretion as to whether the Board or public comment and ask questions first however it is not appropriate for Board members to respond to public comments.

Ms. Ochoa stated Board members may ask questions of the demographer now however comments and questions should be held until the public has an opportunity to speak.

Director Reno questioned how the California Legislation Assembly Bill 350 differs from the Local Healthcare District Law. Ms. Ochoa stated the two provisions do not conflict. She explained the requirements of AB350 which requires two public hearings before maps are drawn and two public hearings after maps are drawn. The Health & Safety Code only requires one hearing where there is an opportunity for the public to speak about its communities of interest.

Ms. Ochoa stated the Healthcare District Law is what we are going to follow to divide the Board into zones; however the California Voting Rights Act is also taken into account with respect to protected classes. She further explained that we are meeting the requirements of the Election Code with the state wide general elections and are districting or zoning the Board pursuant to the Health and Safety Code for Healthcare Districts. She noted the California Voting Rights Act essentially imposes additional requirements, it does not eliminate any.

Director Reno questioned if annexation is necessary for redistricting. Ms. Ochoa responded that no, annexation is not necessary for redistricting and that is why we are drawing two proposed maps with two different boundaries. The demographer will draw maps for the current jurisdiction and draw maps for the proposed annexed jurisdiction. She explained if the annexation goes through before March (our internal deadline to submit the Resolution about districting to the Registrar of Voters so it can be in effect by the 2018 election), we will district the new boundaries. If the annexation is not done by the deadline we will subdivide the current district's boundaries. She emphasized either way there will be district based elections in 2018.

Director Reno questioned if these hearings will be completed on time. Ms. Ochoa referred Director Reno to the timeline presented by Mr. Johnson. She stated we are meeting all of the deadlines that are required by the CVRA.

Director Reno questioned if the maps will be drawn up before November? Mr. Johnson responded that the maps will be drawn up in October.

Director Reno reiterated her concern that the maps be drawn on time.

b. Public Hearing Regarding Change from At Large to District Based Election – Elections Code 10010(a) (1)

Chairman Dagostino opened the public hearing and invited the public to speak on this issue.

Chairman Dagostino recognized Jane Mitchell who asked the following questions:

1) When did annexation start?
2) Who initiated the annexation?

3) Will the annexed areas need to agree to annexation?
4) What will the public input process consist of?

On a separate matter, Ms. Mitchell stated she is in solidarity with the nurses and their issues.

Chairman Dagostino recognized Dr. Lou Montulli.

Mr. Montulli commented that he hopes the Board achieves two goals: 1) That the public will see a clear and simple redistricting and 2) In 2018 you bring the election to a point where Vista has a chance to be represented.

On a separate matter Dr. Montulli commented on the da Vinci.

Chairman Dagostino recognized Mr. Victor Roy. Mr. Roy stated he hopes that the maps are drawn up fairly so that there is equal representation throughout all the districts.

Chairman Dagostino recognized Ms. Elizabeth Warren who questioned if we have spoken to the Registrar of Voters about the ballots to ensure every precinct and voting location has the appropriate ballot by address.

On a separate matter, Mr. Warren commented on the wonderful care her family members have received here at Tri-City.

Chairman Dagostino recognized Ms. Katsuyo Fukuyama. Ms. Fukuyama stated she was under the impression that the Board still had to decide whether to stay at large or go into zones. She was pleased to see that the decision has already been made to go to zones. Ms. Fukuyama commented on the City of Vista's districting process. Ms. Fukuyama stated she believes the zoning will result in candidates spending less money on their campaign and the public will have a better opportunity to provide input.

Ms. Ochoa provided answers to the public's questions as follows:

1) Annexation began in May of 2015 when LAFCO released its sphere of the four local healthcare districts in San Diego County. The study recommended that Tri-City evaluate the potential sphere of influence options that would facilitate future annexations that would be imposed by LAFCO. The goal in the sphere review was to have the proposed annexations (LAFCO came up with Annexations area) by 2020.

2) LAFCO made the recommendation for annexation and they are proposing tightening up the boundaries to follow the three cities of Tri-city.

3) The process follows the timeline that was presented by Mr. Johnson.

4) The Registrar of Voters has provided their deadline dates and the proposed timeline conforms with their deadline.

5) The annexed/deannexed areas do not need to agree with the annexation/deannexaction, however they can object. Ultimately, LAFCO is the agency that has the most discretion. Mr. Moser clarified that taxes are not going to change for anyone due to the change in boundaries; it is merely a boundary change for the district.

Chairman Dagostino closed the public comment portion of the hearing. He invited Board members to speak.

Director Reno questioned when the fifth hearing will be held. Ms. Ochoa stated the fifth hearing is the hearing where the Board will adopt the Resolution with the maps. She stated we are leaving that date flexible depending on LAFCO's response to the annexation. Director Reno continued to express concern on the timing of the fifth hearing. Mr. Johnson assured Director Reno the fifth hearing will be held in ample time to comply with the Registrar of Voters deadline.

Director Grass requested clarification on the number of zones up for election in 2018 and 2020. Mr. Johnson stated three seats will be up for election in 2018 and four seats in 2020.

Director Nygaard questioned if it is possible for the Board to choose to elect the Chairman of the Board district wide and the other Board seats by zone as some cities have chosen to do. Ms. Ochoca stated that could be considered illegal if there is racially polarized voting. Her recommendation is to go district based.

Director Schallock also commented on the date of the fifth hearing and suggested we target for March. He stated it is important to also give the candidates sufficient time to familiarize themselves with the zone they are running in.

Director Schallock commented that he anticipates each city having two zones and the seventh zone may be blended. He stated in 2004 four members of the Board were from Vista and there was no representative from Carlsbad.

Director Schallock also commented that he believes there would need to be a large number of individuals to oppose the annexation to stop it. He reiterated that there will be no tax changes incurred with the annexation/deannexation.

Lastly, Director Schallock commented that yesterday the Little Hoover Commission report came out and part of it was related to district hospitals in relationship to LAFCO. The commission recommended that LAFCO has the statutory authority to address process changes and should be the lead entity involved in district changes versus the legislature stepping in on a case by case basis.

Director Reno questioned if the Board should give direction through a binding motion to have the hearings completed by March. Chairman Dagostino disagreed and reiterated General Counsel's comments on being flexible to accommodate the potential annexation. Director Reno stated she wanted to see a confirmation that this Board is going to comply with the California Elections Code and have zone based elections in 2018. Mr. Moser referred Director Reno to Resolution 785 which was previously approved by the Board promising to abide by the Elections Code.

Chairman Dagostino stated the Board is committed to finishing this as quickly as possible and will adjust on the fly based on direction from the public.

Ms. Ochoa Invited community members to attend the September public hearing on September 28th. She stated this will be another opportunity to give input before the maps are drawn.

In closing, Ms. Ochoa stated Mr. Johnson's PowerPoint presentation is available upon request.

14 Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer reported on upcoming events as follows:

- Tri-City Hospital Foundation Golf Tournament is scheduled for September 18th and is completely sold out. Mr. Newhart gave a special thanks to Mr. Chris Miechowski who has done an outstanding job in engaging hospital vendors for their support of this event.

- The Diamond Ball is scheduled for November 18th with special guest Dana Carvey. Proceeds of the event will benefit the Women's Imaging Center.

- The next issue of the Foundation Newsletter will feature some of the robotic surgeons.

- A new giving club (the GEM Club) is designed for community members to support in a continuous way (monthly). There are different levels of sponsorship and the Diamond Level qualifies the individual for the Diamond Society at the end of the year.

Lastly, Mr. Newhart presented a short video depicting the da Vinci in action at the Boys and Girls Club in Oceanside. Mr. Newhart stated he was proud that Tri-City brought this out to the community and expressed his appreciation to Dr. Fierer for taking his time and inspiring these children with this new technology.

No action was taken.

15 Report from Chief Executive Officer

Mr. Steve Dietlin, CEO stated the presentation and video that was presented earlier was quite impressive. He stated that obtaining things like state of the art equipment happens through collaboration with the Foundation, the Medical Staff, nursing staff, administration and the Board. It is the definition of a collaborative action that meets the communities healthcare needs.

Mr. Dietlin stated meeting healthcare community needs has become more difficult with the ongoing challenges of healthcare reform. Community hospitals and systems alike have been closing facilities and reducing services due to continued reimbursement and pressure to reduce costs and at the same time providing quality healthcare. He stated this theme is expected to continue and there will be increasing pressure to reduce costs while providing the highest quality of care. Mr. Dietlin stated that given this continued pressurized environment it is remarkable to see what Tri-City has been able to accomplish in the past year. Staying true to our mission, we are looking to expand services in this community rather than contract them. Many have discontinued mental health services due primarily to reimbursement challenges. Tri-City has expanded access to outpatient care by collaboration with the county for a Crisis Stabilization Unit and with our UCSD affiliate partner for difficult to find mental health physician coverage. The community, the Board of Directors and everyone that came together recognizes this much needed service and provides it. In addition,

an expansion of the ED triage areas resulted in improved services for mental health and medical patients alike. He noted Tri-City is top ranked for ER off load percentage times and along with that ED arrival to provider times decreased in 2017 by 46% which is incredible.

Mr. Dietlin stated we have also worked to execute key collaborative initiatives with UCSD to enhance and expand services offered to this community including cardiothoracic surgery, mental health coverage, intraoperative radiation therapy along with faculty neurosurgeons who are stationed here in North County performing surgeries right here at Tri-City. Additionally, we recently submitted an expanded relationship with Orthopedic Specialists of North County who are widely known in this community to provide excellent orthopedic services which will ensure those services will be available in this community for a long time to come.

Mr. Dietlin stated Tri-City recently took major steps to secure the financial future of Tri-City by placing 25 year fixed rate long term financing by partnering with HUD. This is a significant step and a major accomplishment that substantially improves the liquidity of the district and allows us to move forward with campus redevelopment.

Mr. Dietlin stated the Board recently approved the FY18 budget and that includes the first phase of the campus redevelopment which we are very excited about.

Mr. Dietlin stated The American Heart Association continues to recognize Tri-City for heart and stroke care which remain the number one and number five causes of death in the United States for men and women. Mr. Dietlin stated we are bringing education and awareness of this important issue to the community through the inaugural North County Heart and Stroke Walk on September 30th. He encouraged everyone to join us at this Community event.

No action was taken.

16 Report from Chief Financial Officer

Mr. Rivas reported on the current month Financials as follows (Dollars in Thousands):

- Operating Revenue – $29,600
- Operating Expense – $30,419
- EBITDA- $898
- EROE – ($394)

Other Key Indicators for the current month driving those results included the following:

- Average Daily Census – 170
- Adjusted Patient Days – 9,221
- Surgery Cases – 511
- Deliveries – 210
- ED Visits – 5,542

Mr. Rivas reported on the following indicators for FY18 Average:

- Net Patient Accounts Receivable - $44.2
- Days in Net Accounts Receivable – 47.7

Mr. Rivas noted a spike in deliveries this month.

Director Reno stated she is concerned in the drop in surgeries. Mr. Rivas stated July is historically a slow month and he expects to see significant improvement in August.

No action was taken.

17 New Business

c. Consideration of Neurosurgery Services

Mr. Jeremy Raimo, Senior Director presented an update on the Neurosurgery Request for Proposal Initiative. Mr. Raimo stated the objective was to seek proposals for neurosurgery groups to take the Emergency Room Call panel. The proposal was sent out to the existing physicians on campus and we received three proposals back, one of which was omitted due to the fact that two of the three physicians did not consent to the proposal submitted. Mr. Raimo explained that the two proposals that were considered were from UCSD and the San Diego Neurosurgical Disorder Services. Mr. Raimo stated in looking at side by side comparison of those proposals, the rates were the same however the commitment of clinical support differed. UCSD offered Clinical Support of 0.5 FTE dedicated to Tri-City and has an office location in Carlsbad. Other factors considered were the time and distance to travel from the physician's office to TCMC. Mr. Raimo stated in looking at the proposals what we tried to do was aggregate the objective measures of not only access, clinical support, follow-up and the development of a robust cohesive neurosurgical group.

Chairman Dagostino stated he believe administration performed a fair objective assessment.

Director Kellett stated the Board has reviewed the proposals and is in support of UCSD providing the neurosurgical call coverage.

It was moved by Director Kellett that Tri-City Healthcare District Board of Directors authorize the Regents of the University of California on behalf of its San Diego School of Medicine, Department of Neurosurgery to provide neurosurgical call coverage for a period of 12 months commencing on September 1, 2017 through August 31, 2018 at a cost of $1000 per day or an annual cost not to exceed $365,000 and a total cost of the term not to exceed $365,000. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18 Old Business

a) Update on LAFCO Application/Annexations

Mr. Moser provided a brief update on the LAFCO Application/Annexation. He reported we hope to have maps from LAFCO by the middle of next which will allow us to submit a completed application to LAFCO. Mr. Moser stated the District will need to submit a check for approximately $25,000 with the application and LAFCO will take care of approximately $85,000 in fees for the annexation and deannexation of areas which they proposed and will also do the mappings for those areas. Mr. Moser stated we expect LAFCO to continue to cooperate and make it easy for us to implement their municipal service review that they proposed two years ago.

Director Reno stated she was not aware that LAFCO would be charging fees. Mr. Moser stated LAFCO is a fee for service operation and charge fees on a per acre basis. He explained the fees that LAFCO has agreed to include the large acreage from Camp Pendleton.

No action taken.

19 Chief of Staff

a. Consideration of July 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on August 28, 2017.

It was moved by Director Grass to approve the August 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on August 28, 2017. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b. Consideration of Rules & Regulations

1) Division of General Surgery

2) Division of Cardiology

It was moved by Director Mitchell to approve the Division of General Surgery and Division of Cardiology Rules & Regulations, as recommended by the Medical Executive Committee at their meeting on August 28, 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**

c. Consideration of Privilege Cards

1) Pediatrics
2) Subspecialty of Surgery – Otolaryngology
3) Cardiology
4) OBGYN
5) Ophthalmology

It was moved by Director Kellett to approve the Pediatrics, Subspecialty of Surgery - Otolaryngology, Cardiology, OBGYN and Ophthalmology Privilege Cards, as recommended by the Medical Executive Committee at their meeting on August 28, 2017. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20 Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Nygaard seconded the motion.

Chairman Dagostino noted for the record an abstention of the July 28, 2017 Regular Meeting minutes due to his absence at the meeting.

It was moved by Director Reno to pull the Special Meeting minutes of August 1, 2017.

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**

21 Discussion of items pulled from Consent Agenda

Director Reno who pulled the August 1, 2017 Special Meeting minutes stated she wanted the Closed Session minutes to be corrected to reflect she was recused from a portion of the meeting, she was not absent. Mr. Moser stated the minutes will be reflected to make clear the reason for the recusal was to protect the attorney client privilege.

It was moved by Director Mitchell to approve the amended minutes of the August 1, 2017 Special Meeting. 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**

22 Reports (Discussion by exception only)

Chairman Dagostino stated his report on the Governance Forum that he recently attended in Sacramento is distributed at the dais and at the back table for the public.

23 Legislative Update –

Director Schallock reported on August 24th, the Little Hoover Commission voted to adopt their Special District report, which includes a special section, "What Role for Healthcare Districts". In the healthcare portion of the report, the Commission calls for special district reforms and recommends several measures to strengthen oversight of healthcare special districts.

Director Schallock stated the Little Hoover Commission recommended an update of the 1945 law establishing the districts. In addition, in the recent past the legislature has undertaken specific legislation regarding individual districts. The commission recommended that LAFCO has the statutory authority to address process changes and should be the lead entity involved in district changes versus the legislature stepping in on a case by case basis. In addition, with boundary issue expansion such as what Tri-City is doing, LAFCO is the correct agency to be involved. The commission recommends that ACHD and its member hospitals need to define best practices and models for district healthcare hospitals. For those doing grants, enhanced guidelines should be developed for improving the impacts of the grants in their community.

Director Schallock stated continued monitoring in these areas will be necessary over the next months.

24 Comments by members of the Public

Chairman Dagostino recognized the following individuals who spoke in support of the nurses and safe patient safety: Becky Rodriquez, Cindy Odo-Amen, Ussef

Miller, Chris Hart, Gigi Narisma, Elizabeth Warren, Brenda Tavares-Hamm, Sarah Guerling and Amenda Mascia. General Counsel also read comments into the record from Nikki Leeds and Pete Beauregard.

25 Additional Comments by Chief Executive Officer

Mr. Dietlin turned his time over to Chief Nurse Sharon Schultz.

Ms. Schultz stated it was brought to her attention that the nurses were signing a petition indicating their refusal to educate new nurses that we bring on effective September 13th in an effort to reduce the numbers of travelers and agency nurses. Ms. Schultz stated as the Chief Nurse and as a district resident and tax payer in the city of Oceanside she is very concerned about the harm this is going to cause our patients. Ms. Schultz stated it is a social and ethical responsibility of all nurses and it saddens and upsets her to think that our nurses would do this.

Ms. Schultz commented that there are very few days that the union has been willing to come to the table and meet. She also commented that most of our nurses that have left have done so due to relocation. Survey data reflects that only 3% of our nurses left for higher salaries. Ms. Schultz stated the issues are more complicated than what is being presented. She explained Travelers are not just used to fill vacancies. She stated there are over 83 nurses out on a daily basis or more on leaves of absence and we must be able to provide staff when our own nurses call off at the last minute or are on leave. She stated we cannot refill their positions as they are protected. With regard to vacancies, Ms. Schultz stated vacancies have come way down. We have 18 opening for nurses and the ER does not have any staff openings at this time.

26 Board Communications

Director Schallock stated he received notification that Kevin McQueen is leaving Tri-City and has accepted a position in Colorado. Director Schallock expressed his appreciation to Mr. McQueen for his time and dedication and wished him much success in Colorado and in his future endeavors.

Director Schallock stated at times the public gets the wrong impression on what we are paying staff. Director Schallock stated the salaries for members of the bargaining team range from $140,962 to $220,000 in 2016. He stated these figures are readily available for public viewing on Transparent California. A member of the audience and union representative Sara Guerling called Director Schallock a "union buster". Director Schallock stated he simply wants to see that everyone get a fair and living wage. Director Schallock encouraged the union to come to the table to reach resolution as soon as possible.

Director Reno read a note from a patient regarding the wonderful care that was received at Tri-City.

Director Reno stated the community is at stake here with safety and healthcare. She stated she was unaware of some of the issues surrounding the nurses.

Director Nygaard had no comments.

Director Grass stated as a registered nurse she too wants the matter resolved with the nurses and would like to see the use of registry down too. Director Grass stated her understanding of the proposal on the table included compensation in excess of $235 million for RN's including $8.3 million in increases over four years with nurses receiving between 7.7% to 38.6% increases and/or lump sums during the term of that contract. Director Grass stated if that information is not correct the Board would like to hear what they believe to be correct. Director Grass stated happy nurses make happy patients and it is her hope that the nurses are happy very soon.

Director Mitchell commented that Board members were not at today's press conference due to the Board meeting which was publicly posted to begin at 1:30 p.m.

Director Mitchell stated the district has been tracking requests for bargaining dates since the first of the year and for every 3-4 requests the district makes they might get one response. Out of those responses 50% or less have resulted in a bargaining date. Director Mitchell stated it is the union's responsibility not the employers to set the bargaining dates. She further stated the district is working very hard and if the union will not accept or suggest bargaining dates the district's hands are tied.

Director Mitchell stated just as concerning to her is the rumor regarding nurses who are not willing to orient new nurses. She stated that it a potential danger to our patients. and she cannot defend insubordination. Director Mitchell further commented that what the nurses are proposing is insubordination which is grounds for termination whether there is a contract or not. Director Mitchell encouraged the nurses to read Section 3505 of the Meyers-Milias-Brown Act.

As a public service announcement, Director Mitchell commented on a personal experience with the City of Oceanside's billing website wherein her bank card was "hacked". She stated individuals who may have experienced the same problem should contact the FBI's Cyber Crime Division to file a report.

Director Kellett did not have any comments.

27 Reports from Chairperson

Chairman Dagostino had no comments.

33 Hearing no further business, Chairman Dagostino t adjourned the meeting at 6:17 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

September 7, 2017 – 10:00 o'clock a.m.
Assembly Rooms 2& 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 10:00 a.m. on September 7, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Greg Moser, General Legal Counsel
Steve Dietlin, Chief Executive Officer
Kapua Conley, Chief Operating Officer
Sharon Schultz, Chief Nurse Executive
Norma Braun, Chief Human Resource Officer
Ray Rivas, Chief Financial Officer
David Bennett, Chief Marketing Officer
Glen Newhart, Chief Development Officer
Scott Livingstone, Interim Chief Compliance Officer
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent
Jim Rice, Board Facilitator

1. The Board Chairman, Director Dagostino, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Chairman Dagostino welcomed Jim Rice, Board Facilitator. Chairman Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Nygaard to approve the agenda as presented. Director Kellett seconded the motion. The motion passed unanimously (7-0).

   Chairman Dagostino reported the agenda will be reordered with Closed Session business to follow the Open Session.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Consideration to waive Board Policy 14-006 – Board of Director Meeting Minutes, Section #3 related to taping of today's meeting.

It was moved by Director Kellett to waive Board Policy 14-006 – Board of Director Meeting Minutes, Section #3 related to taping of today's meeting. Director Schallock seconded the motion. The motion passed unanimously (7-0).

11. New Business

a) Consideration to award Parking Structure/New Entry Drive architectural design contract to Cuningham Group Architecture.

Chairman Dagostino stated this agenda item was discussed in detail at the August Regular Board meeting.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors authorize the bid proposal with Cuningham Group Architecture, Inc. for $594,240.00 for the design of a new parking structure and entry drive related to the campus redevelopment plan. 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**

b) Board of Directors Public Workshop for the purpose of review and discussion of:

1) Review Board Self-Assessment

2) Review, discussion and potential action regarding the following:

a) Committee structure and role of committees

b) Community Healthcare & Alliance Community Grants

c) Board Education

Mr. Rice stated the Board is to be commended as a public body for doing this type of periodic review and assessment. He explained the reports distributed today compare the Board's performance from 2015 to 2017 and also compares the Tri-City Board with other California Healthcare Districts.

Mr. Jim Rice reviewed the results of the Board's Self-Assessment which indicated that the Board has made substantial positive progress compared to the Board's 2015 Self-Assessment and is beyond the state average in certain areas. He explained by analyzing the assessment he hopes to assist the Board in developing a governance enhancement plan that captures a roadmap to enhanced performance of our board work.

Director Mitchell left the meeting at 12:00 noon due to illness.

Mr. Rice also provided a worksheet that identified five areas that he has deemed need improvement based on the Board's responses to the Self-Assessment which includes the following:

1) Community Linkages
2) Physician Support
3) Meeting ROI
4) International Education
5) Financial Library

The attendees spent considerable time participating in table exercises to discuss the five areas of focus previously mentioned. Following the meeting, Mr. Rice provided Board members with a summary of the retreat (attached) which captured observations and strategies that surfaced through the discussions.

In closing, attendees gave their impression of today's retreat. All attendees indicated it was a positive meeting that reflected synergy between the Board, the Executive Team and Physician leadership. Chairman Dagostino expressed his appreciation to Mr. Rice for his candor and leadership.

Mr. Rice commented that Board members were open and receptive to discussions and are building on their accomplishments. He encouraged the Board to consider a follow-up workshop in two-three months.

5. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino deferred this item to the Board's General Counsel. General Counsel, Mr. Moser, made an oral announcement of item listed on the September 7, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Legal Counsel regarding one matter of Existing Litigation.

6. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Schallock to go into Closed Session. The motion passed (6-1) with Director Mitchell absent.

Chairman Dagostino adjourned the meeting to Closed Session at 3:14 p.m.

8. The Board returned to Open Session at 3:58 p.m. with all Board Members present with the exception of Director Reno who did not return after recusal from Closed Session and Director Mitchell who left the meeting early due to illness.

9. Open Session

10. Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

12. There being no further business, Chairman Dagostino adjourned the meeting at 3:58 p.m.

James J. Dagostino
Chairman

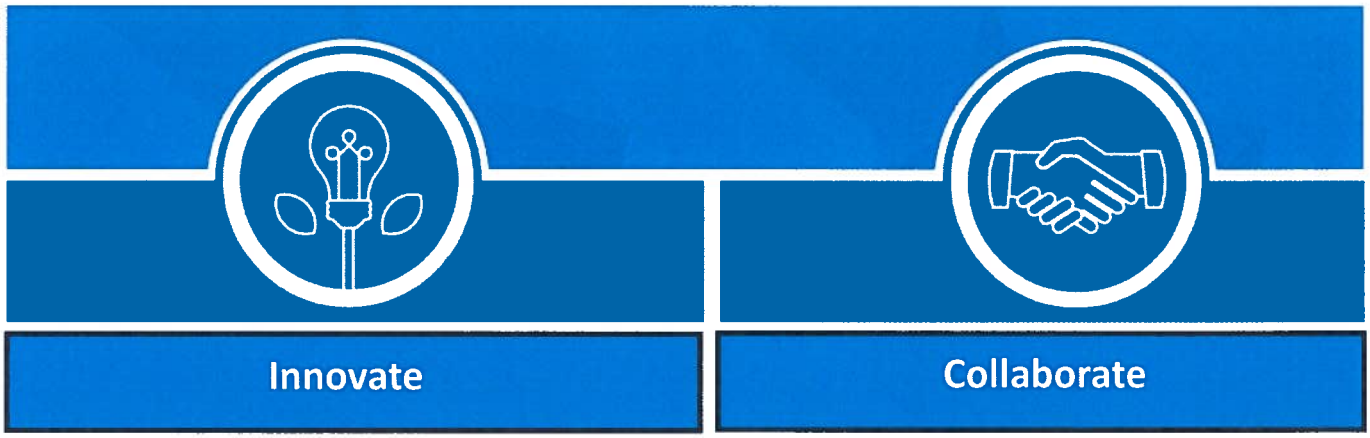
ATTEST:

Laura E. Mitchell
Secretary

Governance Enhancement Plan:

Actions to go from Strength to Strength 2018-2020

Tri-City Medical Center



Retreat Insights from Tri-City Medical Center Governing Board
September 7, 2017

James A. Rice, Ph.D.
Managing Director, Governance & Leadership
Gallagher Integrated
A Division of Arthur J. Gallagher
Jim_rice@ajg.com

Preface

This Guide is designed to help ensure follow-through and follow-up on a series of practical initiatives from the Governance Enhancement Retreat by the Board and Leadership Team of Tri-City Medical Center.

Small and large group discussions during the retreat built from a review of the Tri-City Board Self-Assessment Report developed in conjunction with the Association of California Health Districts (see: http://www.achd.org/) and as facilitated by Jim Rice of Gallagher Integrated, see: http://www.integratedhealthcarestrategies.com/About/Bio/james-a-rice.

The results from the 2017 Board Self-Assessment indicated that the Tri-City Board has made substantial positive progress in advancing its capacity for wise governance of the valued hospital system focused at the Tri-City Medical Center based in Oceanside California, see: https://www.tricitymed.org/about-us/Board-of-directors/

The seven Board Members assessed the Board's overall performance in ten leadership areas, including:

- Mission, values and vision;
- Strategic direction;
- Leadership structure and processes;
- Quality and patient safety;
- Community relationships;
- Relationship with the CEO;
- Relationships with the medical staff;
- Financial leadership;
- Community health; and
- Organizational ethics.

Board members rated 167 total criteria in these ten areas. The survey results indicate the Board has improved its performance scores in a majority of these criteria.

Five areas in which the Board and Executive Team exchanged ideas about how to further enhance the work of the governing Board are:

1. Expanded Community Linkages
2. Strengthened Physician Support
3. Increased Meetings' Returns on Invested Time and Talents
4. Enriched Board Development from Intentional Educational Initiatives
5. Enhanced Financial Literacy

This document provides a summary of the several actions that the Board and senior leadership team intend to accomplish in calendar year 2018.

Expanded Community Linkages

Participants in the Governance Review provided several proposed actions as a means to expand and enhance the working relationships and influence of the Tri-City Board and System with a variety of community stakeholder groups in and around the main communities of the North County Health District (San Diego County's coastal communities of Carlsbad, Oceanside and Vista), including such varied organizations as:

- School districts
- Chambers of Commerce
- Live Well San Diego
- Boys and Girls Clubs
- Economic Development groups
- Community Inter-Faith Organizations
- UCSD and its network of care providers
- Local political leaders
- Media Organizations

An important focus of the discussion was on the "**Community Grants Program**" of the Tri-City Medical Center (TCMC), but as positioned within a broader context of community and marketing programs underway throughout the organization, such as:

- Creative market research and listening efforts throughout the TCMC region among diverse community groups, vulnerable populations, and potential patient user groups
- Community outreach by the TCMC Foundation
- Marketing and Public Relations Communication Strategies
- Marketing and payer contracting for service line relationships with payers and employers in the TCMC region

The Community Grants Program was studied as to its future strategic value; factors that may get in the way of its future success; and actions that could enhance its future effectiveness for the people of the region, as well as for the strategic plans of TCMC. A summary of conclusions regarding these issues is outlined below:

Value of the Grants Program: This initiative is seen as an important investment of approximately $300,000 per year by TCMC to support community organizations that contribute to the health and well-being of the TCMC District. The programs supported by the grants programs in the future should help demonstrably and tangibly contribute to these criteria:

- Protect and promote the health of vulnerable populations in the region
- Support respected community organizations that are aligned with the strategic mission and plans of TCMC, and will leverage the ROI of our grants with other community resources
- Enhance the effectiveness and vitality of community organizations that can meaningfully support the well-being of the people and growth of The TCMC District

Factors that Could Frustrate Success: The program has evolved from its early beginnings over 20 years ago under valued leadership of community volunteers from the TCMC District. The governance of the grants program, now however, is ready for refinements to help ensure its alignment with TCMC and optimal impact for people within the District. The links to TCMC Board, executives and plans has become uncertain. Community and media awareness of the programs and its past results is underdeveloped.

There is a need for stronger communications of its existence, priorities, plans and measurable results. Accountability and transparency of the grant programs can be enhanced in the coming year.

Actions to Enhance Impact of the Grants Program: Draft strategies that were identified for further discussion and prioritization are:

- Reconstitute the "Grants Governance Council" to be chaired by a TCMC Board member with careful recruiting, onBoarding and development of additional new members. All members to have a "position description", a conflicts of interest policy, and term limits (perhaps 2 or 3 three year teams). Members might be drawn from various community health promotion groups, Chambers of Commerce, Livewell San Diego (see: http://www.livewellsd.org/)
- Develop new "Policy Framework" similar to bylaws that explain the mission, plans, criteria to secure grants, and the process/conduct of decision-making by the Community Grants Governance Council to issue grants
- Develop a strategic plan that builds off the heritage of the program, is driven by an updated "Community Health Needs Assessment" in the TCMC District, and aligns it more closely with the mission and plans of the TCMC, and even the Foundation of TCMC
- Develop updated communication plans that celebrate the plans, work and results for the Grants across the district and with the media
- Develop more explicit contracts/agreements with grant recipients about their plans and accountability to show and report results
- Standardize the size and equity of grants to community partner organizations that can leverage the grants to broader and more sustained health gains
- Provide periodic reports from grant progress that impact the full TCMC Board and Community at large

Community Relations and Marketing Strategies for Board Engagement and Leadership:

Participants encourage the Board to consider these actions for the future vitality of TCMC community linkages, image and brand development:

1. Board needs to Commit for the ongoing assessment of the impact and ROI on all marketing, PR, advertising and communication programs
2. Board should be a key champion for our TCMC "Culture for Service Excellence from the Top"
3. Develop an updated "Strategic Marketing and Brand Development Plan" that aligns with the Strategic Business and Financial plans for TCMC
4. Communication plans are fact and data based/driven to build support for TCMC services and programs, as well as philanthropic support for our programs and partnerships
5. Coordinate communications and marketing with the Foundation and Grants initiatives
6. Encourage Board members to sign up for community events and go with staff to celebrate messaging to targeted community groups, events and activities
7. Study feasibility of 2-3 types of "Community Advisory Councils" to broaden our relationships and inputs to our plans and results
8. Support development of our 2200 employees as our best ambassadors to the communities we exist to serve. This should include a culture of appreciation from the Board for all the work they do for the people we serve
9. Consider media training for our Board, Executive and Physician Leaders
10. Weave positive performance and momentum that is now evident across TCMC into all of our messaging, especially to show we are good stewards of the community and government's money, and our quality and patient safety represents excellent value for their willingness to entrust their care to us
11. Be more intentional in nurturing community partnerships that promote healthy communities and people and employees working across the region (like our work with Livewell San Diego)
12. Ensure we continue to put a human face on what we do for real patients by real care givers and service providers
13. Study how Orange County providers are doing their community linkages,
14. Enhance our co-branding with our local and UCSD providers and programs
15. Leverage our social media tools

16. Others?

Strengthened Physician Support

Participants in the Governance Retreat recognize the value of strengthening our relationships with our many physician colleagues and partners. The following initiatives are suggested for further refinement by the Board and Executives of TCMC, (perhaps under the auspices of the Governance Committee and the MEC?):

1. Continue to support and enhance our reliance on the MEC to link Board, physician and management leaders for joint planning, coordination, and collaboration to strengthen TCMC performance
2. Study the feasibility of hiring a Chief Medical Officer (CMO) as member of our Senior Management to help champion and guide our partnering and alignment with physicians and their practices
3. Continue to invest in making available great technologies, facilities, staff and appreciation for physicians
4. Do more joint strategic and financial planning together
5. Invite physician leaders to carefully planned interactions within selected Board meetings
6. Arrange more social interactions and mixers
7. Engage physicians and nurses to continually educate Board members on the challenges of service delivery, quality of care, and patient safety
8. Invest in physician engagement and satisfaction studies
9. Organize more physician appreciation events and programming with Board thank you's
10. Feature physicians in our program marketing
11. Study how other organizations are using medical directorships to engage and align with our physicians as partners and colleagues
12. Improve our communications with physicians so they know we care about keeping them informed and supported by our work
13. Others?

Increased Meetings' Returns on Invested Time and Talents

Participants acknowledge that we meet too often and consume a great deal of time from the Board and Managers. We need to carefully study every meeting to be sure it is essential, the agenda is smart, the materials needed for decision-making are easy to understand and not overpowering. Other actions to consider are:

1. Seek help from the Association of California Health Districts to explore new flexibility in interpreting constraints of the Brown Act, for example only meeting six times with a normal agenda and using the other meetings for education, planning and partnership collaborations.
2. Make sure that we adopt a moving 18 month calendar of "Themed Meetings" so we as Board Members and our Executive team can plan for deeper dives into key topics and issues
3. Make sure every Committee or sub-group has a written charge, an annual work plan, and defined membership and guests.
4. Develop and maintain a running tally of the hours we invest into meetings, and ask if we are getting the ROI we need
5. Continue to use consent agenda to sharpen our focus and time efficiencies
6. Try to move more committees to quarterly meetings

7. Explore how a Board Member "Portal" or intranet can make it easier for us to track work and agendas of committees, and our works as a Board. Our Board packets are getting too big to print.
8. Others?

Enriched Board Development from Intentional Educational Initiatives

The Board is committed to continuously enrich and expand its access to and use for modern educational programming and materials. Suggestions from the retreat include:

1. Enhance our new Board Member orientation program, and include a mentoring program
2. Build 15 minute "educational insights" in at least three of our Board meetings each year. The "faculty" for these mini-sessions could be our managers, physicians, nurses, Allied Health staff, patients, or outside speakers
3. Study state of the art multi-media Board education programs
4. Consider "Study Tours" to other hospital systems in state or neighboring states
5. Encourage staff and Board member attendance at targeted educational programs by State and National Hospital Board conferences
6. Poll each Board member to define their priority topics for future education opportunities
7. Collaborate with others for quarterly "webinars" with ACHD, California Hospital Association, or even Orange County provider systems
8. Consider speakers brought into occasional joint meeting with physicians and nurses
9. Conduct poll to prioritize Board needs for "refresher" sessions on such topics as:
    - Health economics
    - Population health
    - The economic value of our payroll for over 2200 employees in the region
    - Bundled payments
    - Patient safety
    - New facility designs
    - Clinical care pathway designs
    - Others?
10. Expect all Board members that attend educational programs to share insights and ideas with the full Board
11. Others?

Enhanced Financial Literacy

The 2017 Board Self-Assessment identified a hunger from several Board members to better understand the challenging and complex arena of health industry financing, and the new value based payments.

Questions that are bubbling up are:

- How are we being paid now, what are our source or revenues?
- With our debt refinancing, how much are we saving the community in interest?
- What are our costs and sources of revenue by service and department?
- How are we going to be paid in the future?
- What does a Board member really need to understand for us to develop strategic fiscal performance targets, and to monitor our progress toward our financial targets?

- What are the essential 3-5 financial performance ratios we need to track, how are they developed and what factors influence their changes?
- How does our cost per units of service like admission compare to competitive hospitals in the region?

We should be a bit more intentional in developing our financial literacy and draw upon information, materials, and education programs from:

- Our executive and finance staff
- California Hospital Association staff
- Local health management school faculty
- Publications from the AHA, CHA, Health Financial Management Association (HFMA)
- Tag team with our CFO and CFO from another system
- Others?

We need to explore fresh ways to display our financial results and performance. Can our current "dashBoards" or "report cards" be enhanced so we can "make our numbers sing to us about what is happening"?

As we enhance our focus on investing for sound financial results and great quality, how can we explore incentive compensation for our Senior ExecutiveTeam that consider these performance metrics?

Trustee

RENEWAL INVOICE

Health Forum
P.O. Box 92567
Chicago IL 60675-2567

INVOICE #46646
DATE: August 28, 2017

TO: TERI DONNELLAN
EXEC ASST
TRI-CITY MEDICAL CENTER
ADMIN
4002 VISTA WAY
OCEANSIDE CA 92056-4506

Make Check Payable & Remit To:
Health Forum
P.O. Box 92567
Chicago IL 60675-2567

INVOICE #	PURCHASE ORDER	EFFORT #	EXPIRE	TERM
46646		RNEG2	NOV/DEC 17	10 / YR

We hope you have been enjoying your subscription to ***Trustee*** magazine. We are contacting you to let you know that your subscription is about to expire. We have included a member list for your convenience on the back of this notice, please make any corrections, additions or removals to the list and return in the envelope enclosed along with your payment.

Each individual US subscription is $59 per year for the digital magazine and $79 for both the print and digital magazine. If your organization is currently a member of the AHA, your governing board president will receive one free annual subscription to ***Trustee***. If you need assistance, please feel free to call **a customer care specialist at 800-869-6882.**

Please include a copy of this notice, make checks payable to Health Forum and remit to:
Health Forum P.O. Box 92567 Chicago IL 60675-2567

If you have already sent in your renewal notice, "thank you" and please simply disregard this notice.

Please provide your e-mail address to access online content:

E-mail: _____

Contact ***Trustee*** anytime:

Phone: (800) 869-6882

Email: trucustomer@healthforum.com

Publishers of:

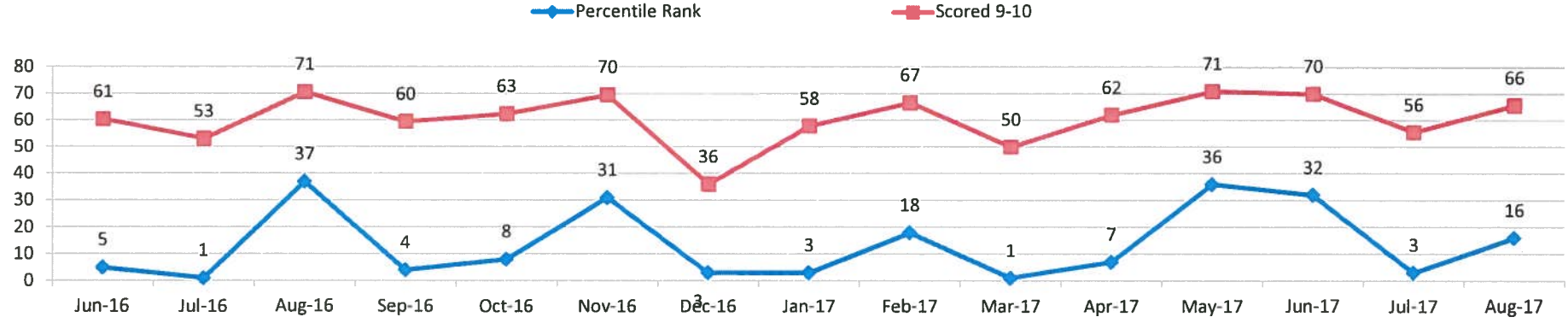
HEALTH FACILITIES MANAGEMENT

H&HN HOSPITALS & HEALTH NETWORKS

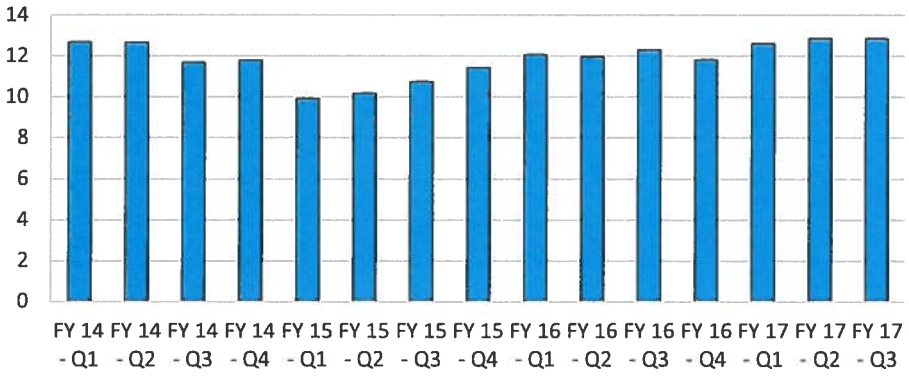
Trustee

Stakeholder Experiences

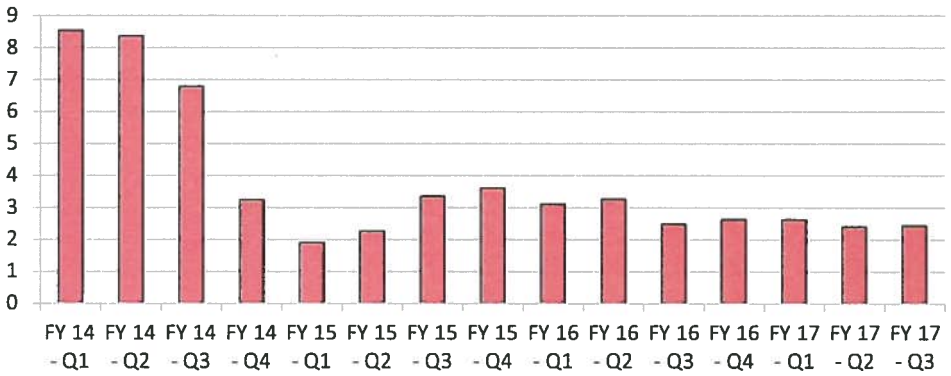
HCAHPS: Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate

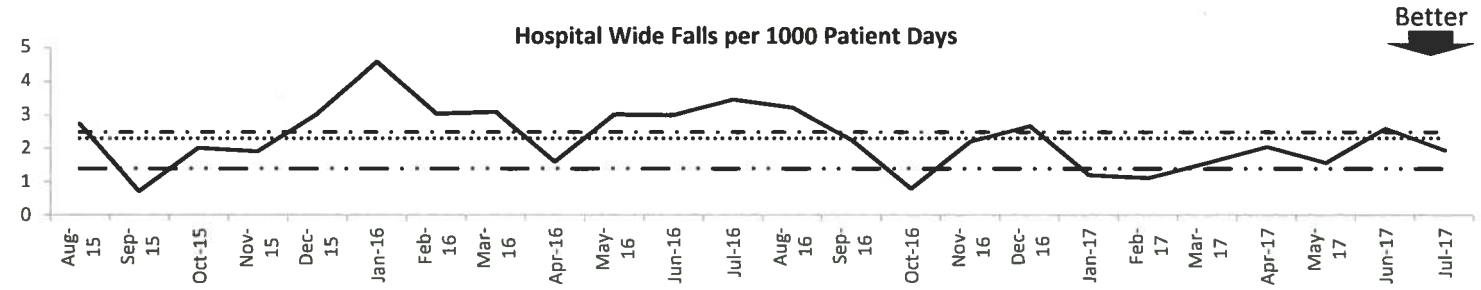


Involuntary Employee Turnover Rate

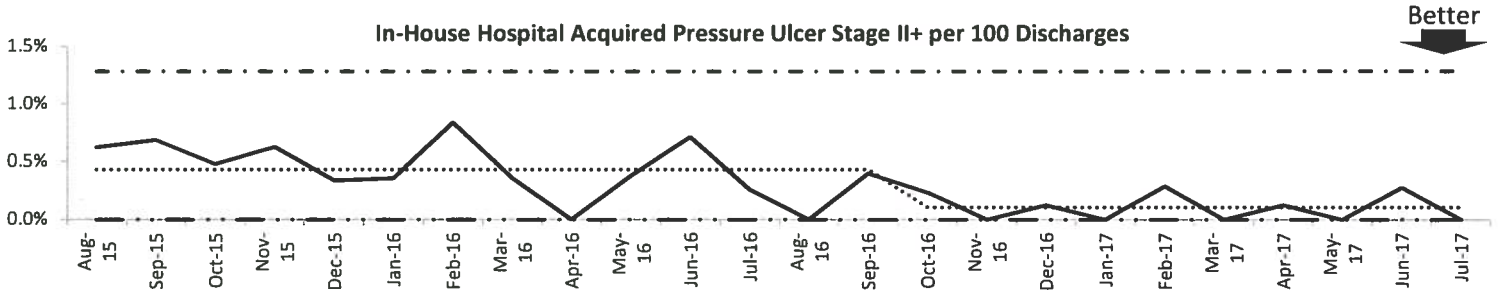


Current Trending Measures

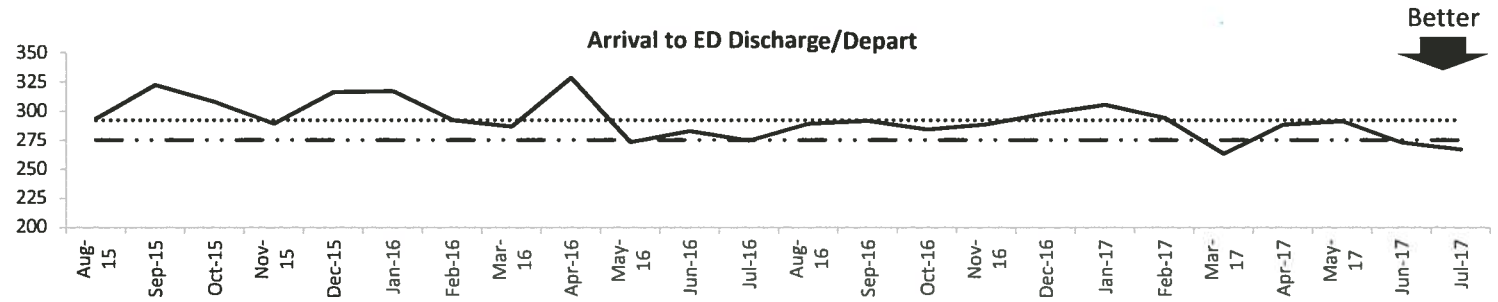
TCMC Mean CA Mean TCMC Target



Action Plan



Action Plan

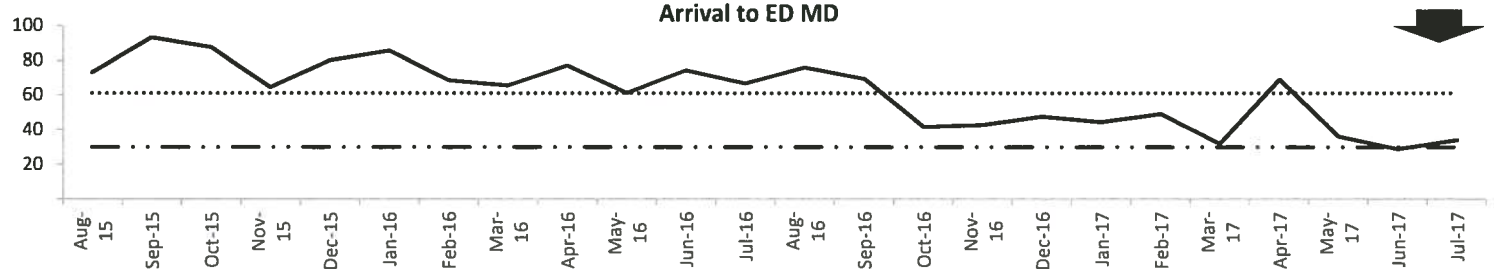


Action Plan

Current Trending Measures

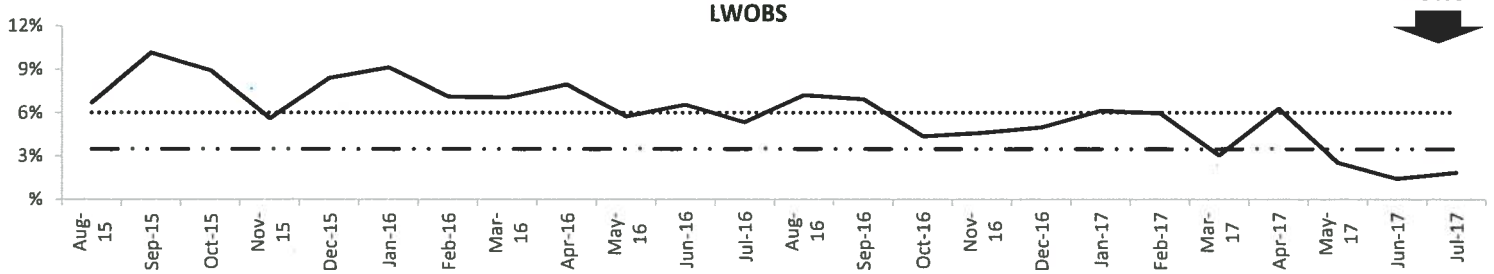
TCMC Mean CA Mean TCMC Target

Arrival to ED MD



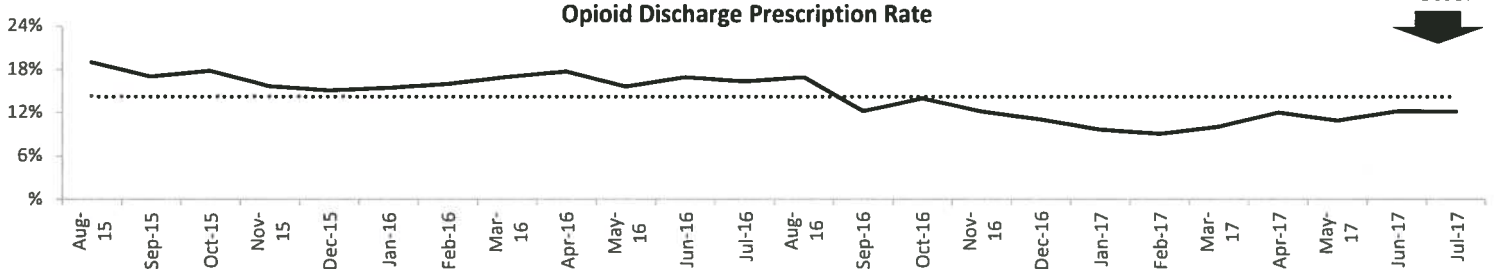
Action Plan

LWOBS



Action Plan

Opioid Discharge Prescription Rate



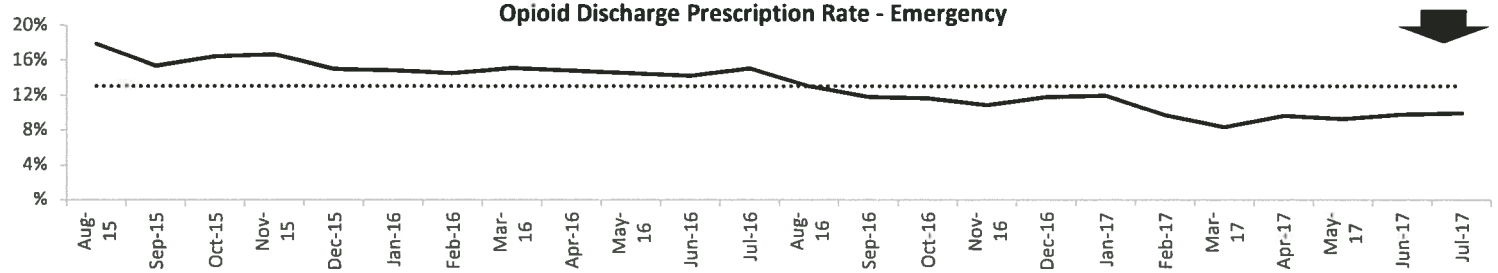
Action Plan

Current Trending Measures

TCMC Mean CA Mean TCMC Target

Opioid Discharge Prescription Rate - Emergency

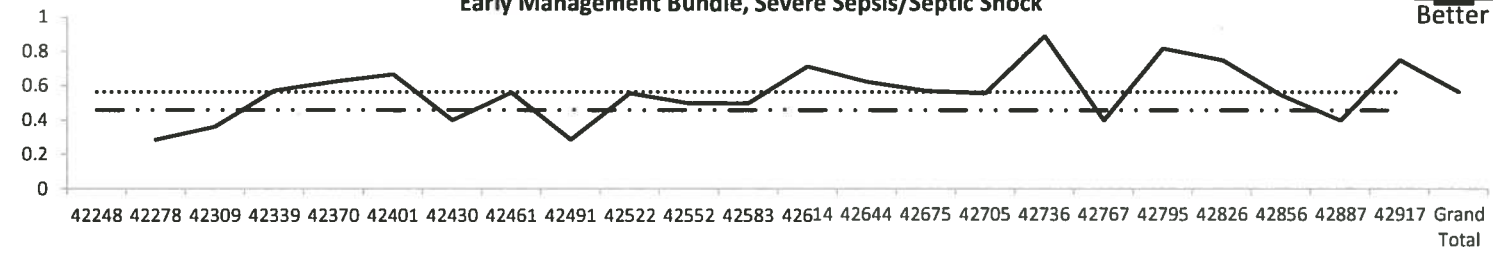
Better



Action Plan

Early Management Bundle, Severe Sepsis/Septic Shock

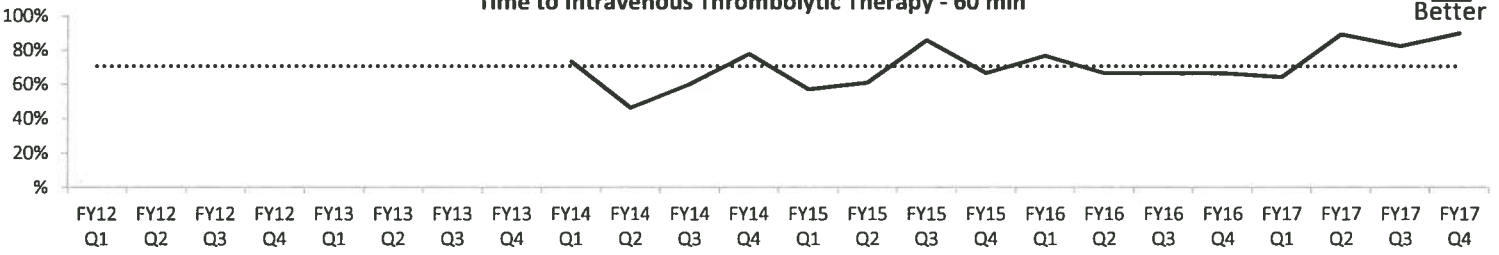
Better



Action Plan

Time to Intravenous Thrombolytic Therapy - 60 min

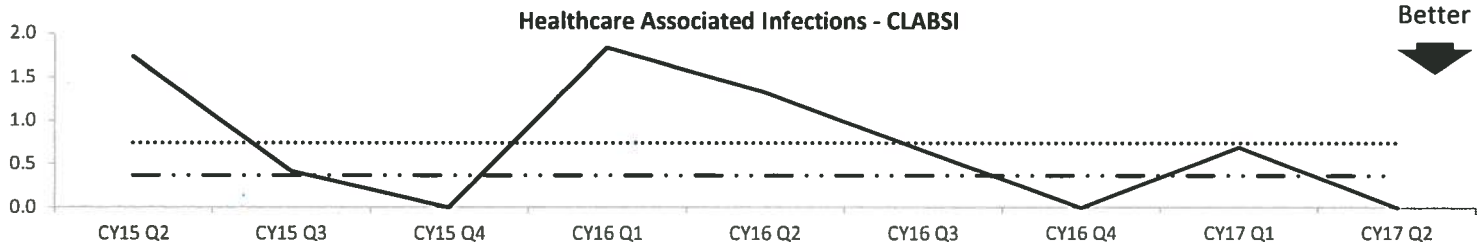
Better



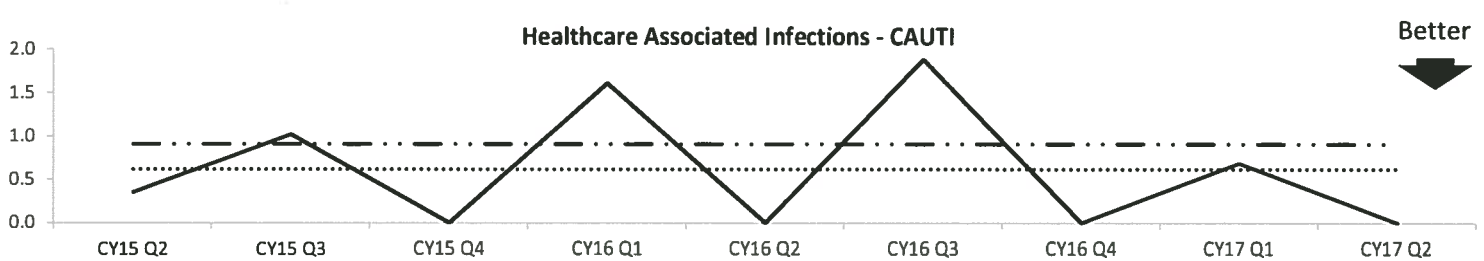
Action Plan

Current Trending Measures

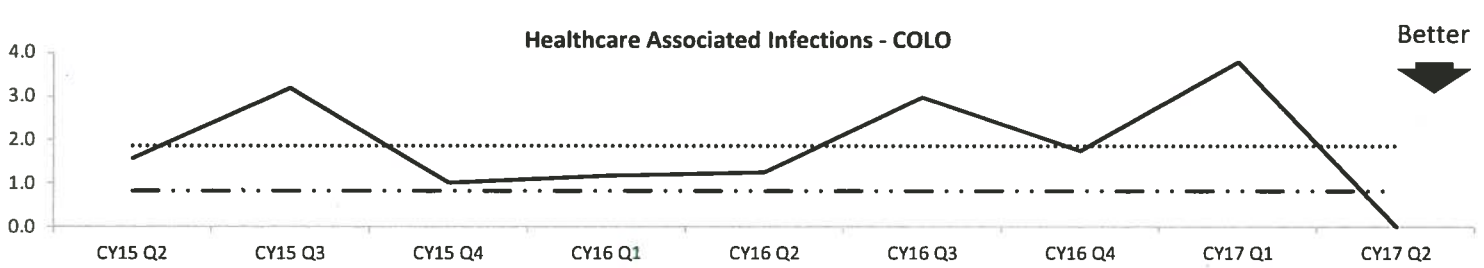
TCMC Mean CA Mean TCMC Target



Action Plan



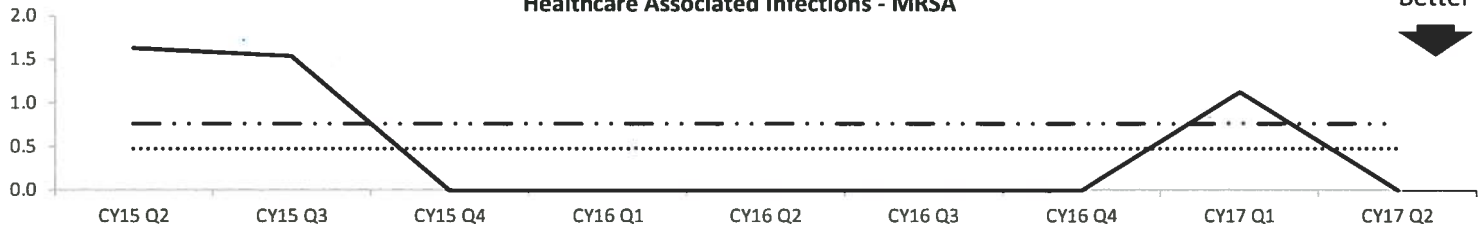
Action Plan



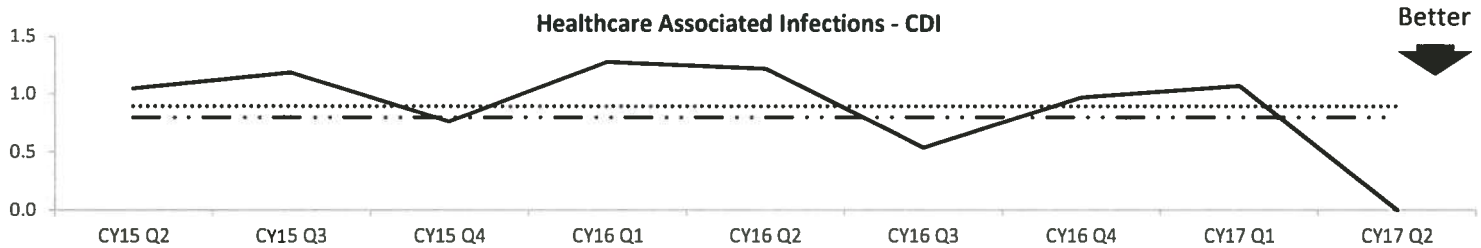
Action Plan

Current Trending Measures

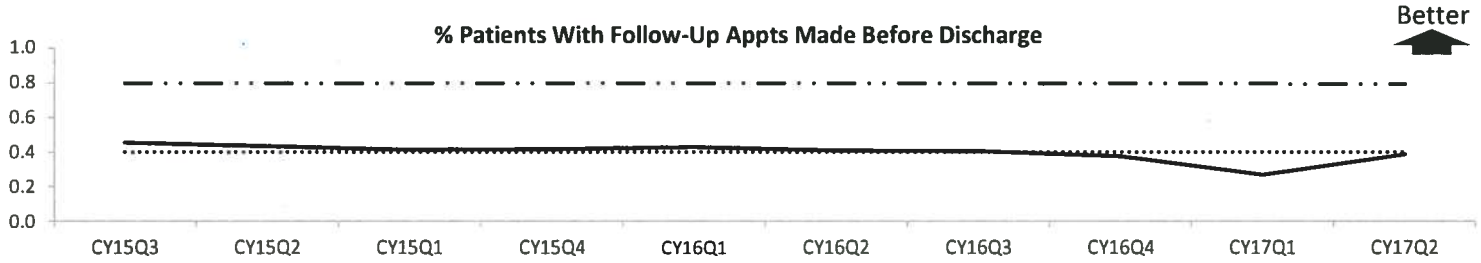
TCMC Mean CA Mean TCMC Target



Action Plan



Action Plan



Action Plan

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	26	23										49
FY17	28	22	13	25	27	23	19	24	25	25	30	261

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	14	6										20
FY17	9	9	5	13	12	11	10	8	15	8	12	112

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	11	12										23
FY17	8	11	8	13	12	8	12	10	12	11	17	122

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	15	20										35
FY17	18	18	17	14	20	22	20	16	18	13	17	193

Performance compared to prior year: Better Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	48	37										85
FY17	31	35	29	42	34	29	31	30	31	37	28	357

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	15.7	14.5										15.1
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1	17.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	9.0	6.7										7.9
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0	6.2

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	11.3	16.4										13.9
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0	15.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	169.7	181.9										175.8
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9	191.9

Performance compared to prior year:	Better	Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	210	222										432
FY17	223	239	274	230	197	200	217	197	202	172	188	2,339

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	12	11										23
FY17	12	11	12	16	11	14	15	11	6	15	12	153

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	4	7										11
FY17	4	4	6	6	5	7	2	2	7	9	6	59

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	8	7										15
FY17	10	9	8	7	6	9	8	6	16	9	6	94

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD
FY18	1.75	1.80										1.77
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71	1.62

Performance compared to prior year: Better Worse

Financial Strength

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
FY18	47.7	47.8											47.7	48-52
FY17	51.2	50.2	48.7	50.5	49.6	50.5	48.9	49.0	48.8	49.4	48.1		50.7	

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
FY18	82.1	79.1											80.6	75-100
FY17	78.9	81.6	86.5	88.1	91.6	87.9	84.6	79.9	74.6	79.9	81.5		80.3	

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
FY18	($394)	($429)											($824)	($942)
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296		$499	

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
FY18	-1.33%	-1.39%											-1.36%	-1.58%
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%		0.89%	

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
FY18	$898	$864											$1,762	$1,632
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)	$1,213	$1,558		$3,079	

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
FY18	3.03%	2.80%											2.91%	2.74%
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%		5.51%	

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
FY18	6.51	5.92											6.20	6.28
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18		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	
FY18	1.57	1.48											1.10	
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	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY18	$58.5	$49.8											
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9		

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending August 31, 2017

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.48	(a)	44,164.55	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011
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	**PCP Clinic - Venus** 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)	10,455.85	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
CreekView Orthopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	15,184.80	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Eflin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.49	(a)	9,642.26	12/01/15	12/31/20	**PCP Clinic - Clancy** 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	08/31/17	**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)	10,258.15	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
Tri-City Orthopedic Bldg Partners 3905 Waring Road Oceanside, CA 92056 **V#83020**	10,218	$2.50	(a)	27,970.32	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Total				**$ 186,818.53**			

(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 8/31/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	CHEMOTHERAPY BIOTHERAPY RENEWAL COURSE	80217	103.00	77556	HEATHER HUNTER
6340	BEHAVIORAL HELTH CARE SYMPOSIUM	82817	535.00	14364	JOY MELHADO
7500	SUPERVISORY PROGRAM	51617BAL	157.56	40874	WILFRED BAGUBE
7772	APTA INSTRUCTOR PROGRAM	41117	270.65	82982	NICK YEARBY
8631	AFP CONFERENCE-AIR FARE	86	235.76	79486	R SAUCIER, D PORTER
8631	AFP CONFERENCE-HOTEL	177	967.47	79486	R SAUCIER, D PORTER
8631	AFP CONFERENCE-REGISTRATION	177	599.00	79486	R SAUCIER, D PORTER
8660	HASC 2017 WELLNESS CONFERENCE	71817	641.17	14289	JILL R. BYRD
8740	CULTURE IN BREASTFEEDING	82417	100.00	81587	MARISSA ALLEN
8740	ACLS RENEWAL COURSE	72717	100.00	83029	CHRISTINE DE LEON
8740	CHEMOTHERAPY BIOTHERAPY RENEWAL COURSE	80317	139.00	82992	ALLISON MESHAKO
8740	ACLS RENEWAL COURSE	81017	150.00	66710	MIRIAM C TIVAR
8740	ACLS RENEWAL COURSE	81017	150.00	80026	BARBARA ALCARION
8740	ACLS RENEWAL COURSE	82417	150.00	80476	MYRNA UBINA
8740	ACLS RENEWAL COURSE	72717	200.00	77475	FLORENCIA BEATRICE JONES
8740	SOCIETY OF NUCLEAR MEDICINE CONFERENCE	82417	200.00	77784	HAMID WALEH
8740	ACLS RENEWAL COURSE	72717	200.00	78113	GLORIA DHARMAPAL
8740	ACLS RENEWAL COURSE	72717	200.00	83028	SOPHIA LIGON
8740	RN TO BSN DEGREE	72717	2,500.00	82011	LAURA GIPSON
8740	MSN DEGREE	72717	3,250.00	82517	KELLY GAVAGHAN
8740	MS NURSING LEADERSHIP & MANAGEMENT	80317	3,745.00	81443	PAMELA MILLS
8740	MSN DEGREE	81017	5,000.00	81933	TERESA Y LITHGOW
8758	HQI CONFERENCE	81417PIEARSON	780.00	82808	JAMI PIEARSON
8790	HEALTHCARE PROF EMGERENCY TRAINING-HOTEL	73117	569.36	81163	JEFF SUROWIEC

**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.

September, 14, 2017

Report to the Board

James J. Dagostino, Chairman of the Board TCHD

ACHD Conference, San Diego, California September 13 and 14, 2017

Day 1 started with The Women's Leadership Breakfast. Speakers Mary Salas, Mayor Chula Vista, Connie Conway, Former California Assembly Leader and Michelle Bholat, MD Trustee Beach Cities Hospital District. Connie is an old friend from my Sacramento days so it was nice to talk with her. All of the woman shared their thoughts about the difficulty of women in leadership.

I attended the Breakout session The Board &Policy-making: Getting Clear on Roles. Brent Ives BHI Consulting. Brent had strong thoughts about a Board and its policy responsibility. It seems that we at Tri-City follow most of what he was suggesting. He suggested policies about Board Conduct, CEO compensation and roles of Committees. His comment that policies reflect best practices and the values of the community rang with me.

Most interesting was a luncheon presentation by Gyre Renwick, Head of Healthcare and Governance, Lyft Corporation. Lyft has a healthcare ride division that works with insurance carriers as well as hospitals. They will guarantee rides home from and to appointments as well as from discharges from hospitals. They have contracts with such companies as Blue Shield, Blue Cross and even Medicaid. It seems that all of the liability for this transportation is covered by Lyft. It would seem valuable for us to talk to these people regarding getting our patients home from the emergency room.

Day 2 started with a legislative presentation from the ACHD the legislative staff. It seems that most of the year was spent testifying in front of the Little Hoover commission. ACHD felt comfortable that recommendations coming out of little commission were relatively innocuous. However a piece of legislation AB 1728 will most likely be signed and maybe something that Tri-City has to deal. Legislation talks about compliance with your website. In a luncheon presentation it seems that CEO Bobbi Palmer Fallbrook healthcare district has worked with a company that has placed their website in compliance. It may be valuable for our IT department in May and possibly legal counsel to discuss the ramifications of a B1728 and possibly talk to this company by the name of Streamline. (I have attached their information to this report.)

A second most interesting piece is that due to the Little Hoover Commission recommendations ACHD has put together a working group to do an omnibus bill to make changes to district law. They hope to have this bill ready for an author in 2018. Although Amber King, Senior legislative advocate was not excited about tackling the stipend section of district law, I have spent some time garnering support possibly adding this to the omnibus bill. It would seem valuable for our board to discuss this issue.

A lunchtime presentation on the future of covered California was presented by Bert Margolin, lobbyist in past legislator. Margolin has a wealth of knowledge and is still active in the healthcare game. His insight

into covered California was interesting. Certainly is a firm believer in federal health involvement in healthcare but is not in favor of the single-payer plan.

Recommendations

1 Provide our IT department and legal counsel the particulars on AB 1728 and possibly work in any needed adjustments as we progress with our board portal.

2 Add to an agenda item language amending board compensation for possible edition to the omnibus bill.

PAGE. 1/ 1
7607203756
Sep.14.2017 04:44 PM Carol Dagostino
R=95%
Page001
ID:Administration
From:7607203756
SEP-14-2017 04:42 PM

STREAMLINE

Website Tips Checklist for California Healthcare Districts

Requirement	Checkpoint	Additional Information
Open Data	☐ Anything we post online and call "open data" meets the requirements for open data (per AB 169)	California law defines what the term "open data" means, for content posted to an agency website
Website: AB 1728	☐ We have a website which includes district contact information, as well as other optional information	**Healthcare districts only**, likely to be signed 2017 and enacted early 2018
Section 508 (Federal)	☐ Our site meets ADA (Americans with Disabilities Act) requirements and passes a scan from a Section 508 scanner	Required so that people with disabilities can access your website. Check at Achecker.com, a popular scanner to test for compliance
Public Records Act: SB 272	☐ We have created our Enterprise System Catalog, made copies available at our office, and posted it to our website (note: you have to create it even if you don't have a website)	This catalog listing your computer systems that meet certain requirements. Learn more about the law or sign up for the free compliance tool at getstreamline.com/sb272
Public Records Requests: AB 2853	☐ We post the content most often requested by our constituents, and most often requested via Public Records Act request, to our website in an easy to find location	This can save the cost of making copies thanks to newly-passed AB 2853, allowing you to refer to your website when complying with PRA requests. In addition, it helps reduce phone calls!
Brown Act	☐ We post all agendas 72 hours in advance for general meetings–including on our website, if we have one	Original Brown Act requirement
Brown Act: AB 2257	☐ A link to our most recent agenda is posted directly to the home page of our website, if we have one	New Brown Act requirement coming in 2019. Must also be "retrievable, downloadable, indexable, and electronically searchable" - text based PDFs work
Financial Transaction Report	☐ Last year's FTR is submitted to Controller's office, and posted to our website (if we have one) "within 7 months after the close of each fiscal year"	You can find more at: tinyurl.com/special-district
Compensation Report	☐ Compensation report is submitted to Controller by April 30 each year; full report or a link to the PublicPay website is posted in a conspicuous location on our website	Instructions and more information can be found on the Controller's site at tinyurl.com/district-compensation
Mobile Friendly	☐ Our website passes Google's Mobile-friendliness scanner so that we appear in search results on mobile devices	Prevent ranking penalties, check out the free scanner at google.com/webmasters/tools/mobile-friendly/

More info: sloane@getstreamline.com (916) 900-6619