TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 14, 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 Legal Counsel – Existing Litigation (Authority Government Code Section 54956.9(d)1, (d)4 1) RoseMarie Reno vs. Tri-City Healthcare District Superior Court Case No. 37-2017-00040507-CU-CR 2) Medical Acquisitions Company vs. Tri-City Healthcare District Case No: 2014-00009108 3) Tri-City Healthcare District vs. Medical Acquisition Company Case No: 2014-00022523		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: December 31, 2017		

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

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

	Agenda Item	Time Allotted	Requestor
	d. Approval of prior Closed Session Minutes		
	e. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 1 Matter)		
	f. Public Employee Evaluation: Chief Executive Officer (Authority: Government Code, Section 54957)		
	g. Evaluation of Legal Counsel Services (Authority: Gov. Code section 54957)		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) .		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Special Presentation – AHA Association Banner - Jennifer Sobotka and Agnes McGlone	5 min.	CMO
13	Special Recognition – Diane Sikora, RN, CMSRN San Diego Business Journal's *Women Who Mean Business Award*	5 min.	CNE
14	Educational Report – Webinar presentation by California Healthcare Association *How California Hospitals Get Reimbursed for the Care they Provide*	60 min.	Chair
15	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
16	Report from TCHD Foundation – Glen Newhart, Chief Development Officer	10 min.	Standard
17	Report from Chief Executive Officer	10 min.	Standard
18	Report from Chief Financial Officer	10 min.	Standard
19	New Business		
	a. Consideration and possible action to elect Board of Director Officers for calendar year 2018	10 min.	Chair

	Agenda Item	Time Allotted	Requestor
	b. Consideration to award Surface Parking Lot contract to Sierra Pacific West	5 min.	COO
	c. Consideration of 2018 Board Committee Schedule	5 min.	Chair
	d. Consideration of CEO Contract	10 min.	Ad Hoc CEO Evaluation Committee
	e. Consideration of amendments to Flexible Benefits Plan	10 min.	Ad Hoc CEO Evaluation Committee
20	Old Business		
	a. LAFCO Update	5 min.	Board Counsel
	b. CVRA Community Meetings Recap	10 min.	Board Counsel
	c. Amended 2018 Board Meeting Schedule	5 min.	Chair
	d. Board Portal Training – Information only e. Board Retreat Follow-up 1. Board Committee Recommendations regarding committee composition and meeting frequency a. Finance, Operations & Planning Committee b. Professional Affairs Committee	5 min. 5 min.	Director Mitchell FOP Chair/PAC Chair
21	Chief of Staff a. Consideration of November 2017 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on November 27, 2017	5 min.	Standard
22	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 *(No meeting held in November, 2017)* **B. Employee Fiduciary Retirement Subcommittee** Director Kellett, Subcommittee Chair Open Community Seats – 1 *(No meeting held in November, 2017)*	5 min.	Standard HR Comm. Emp. Fid. Subcomm.

	Agenda Item	Time Allotted	Requestor
	C. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(No meeting held in November, 2017)*		CHAC Comm.
	D. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 3 *(Committee minutes included in Board Agenda packets for informational purposes)* a) Approval of an agreement with Dr. Martina Klein for Co-Medical Directorship for a term of 31 months, beginning December 1, 2017 through Jun 30, 2020, for an hourly rate of $140, an annual maximum cost not to exceed $35,120 and a total cost for the term not to exceed $90,706. b) Approval of an agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2018 through December 31, 2018, for a cost of $3,077 per month, for a total cost for the term of $36,924. c) Approval of an increase in term cost for the existing agreement with Premier Laser Services LLC, with a term beginning April 4, 2016, through April 3, 2018, with a new not-to-exceed cost for term of $525,000. d) Approval of an agreement with Premier Laser Services, Inc. for laser, ESWL (Extracorporeal Shock Wave Lithotripsy), ultrasound and CUSA (Cavitron Ultrasonic Surgical Aspirator) rental for term of 24 months, beginning April 4, 2018 through April 3, 2020, for an annual cost of $275,000, and a total cost for the term of $550,000. e) Approval of an agreement with South Coast Perfusion, LLC for Perfusion Services for a term of 24 months, beginning February 1, 2018 through January 31, 2020, for a total term cost not to exceed $350,000. f) Approval of an agreement with Katherine Ludington, M.D. for shared marketing services for a term of 12 months, beginning December 1, 2017 through November 30, 2018, for an annual cost of $8,000 and a total cost for the term of $8,000 ($4,000 for each entity). g) Approval of an agreement with Good-Men Roofing & Construction, Inc. for construction costs of $124,263 and the total expected project cost of $257,082 for addition of the new SonoCine Room in the Women's Imaging Center. h) Approval of an agreement with Cerner for Enterprise Dragon for a term of 60 months, beginning January 1, 2018, through December 31, 2022, for an annual cost of $302,950, and a total cost for the term of $1,514,752. i) Approval of a Lease Agreement for Suite 200 in the Carlsbad		FO&P Comm.

	Agenda Item	Time Allotted	Requestor
	Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Lansara, Inc. for a ten-year term (120 months), at the rate of $7,786.50 per month for the first year, increasing 3% yearly thereafter, and also tenant improvement costs of $269,037 for Suite 200 in the Carlsbad Wellness Center MOB.		
	E. Professional Affairs Committee Director Mitchell, Committee Chair *(Committee minutes included in Board Agenda packets for informational purposes)*		PAC
	1) <u>Patient Care Policies and Procedures</u> a. Code Pink in Women's and Children's Services Standardized Procedure b. End of Life Policy c. Monitor Technicians (MT's): Communication Process d. Newborn Screening Collection of Specimen Procedure e. Pet Therapy Policy f. Pre-printed Orders Policy g. Referrals to Social Services for Patients Identified to be High Risk Policy h. Venipuncture for Specimen		
	2) <u>Unit Specific – Behavioral Health Services</u> a. Administration of Antipsychotic Medication		
	3) <u>Unit Specific – Engineering</u> a. Utility Management Plan 4003		
	4) <u>Unit Specific – Environment of Care</u> a. Life Safety Management Plan b. Safety Plan c. Security Management Plan		
	5) <u>Unit Specific - Outpatient Behavioral Health</u> a. Transportation of Patients (DELETE)		
	6) <u>Unit Specific – Rehabilitation</u> a. Pet Therapy- Tender Loving Canines (DELETE)		
	7) <u>Formulary Requests</u> a. Colloidal Oatmeal (DELETE) b. Dicylomine Vial for Injection (DELETE) c. Fentanyl Lozenges (DELETE) d. Lactase Enzyme Tablets (DELETE)		
	F. Governance & Legislative Committee Director Dagostino, Committee Chair Open Community Seats - 0 *(Committee minutes included in Board Agenda packets for informational purposes)*		
	A) Board of Director Policies:		

	Agenda Item	Time Allotted	Requestor
	1) Approval of Board Policy 17-001 – Budget for Medical Equipment or Medical Services (DELETE) 2) Approval of Board Policy 17-009 – Requests for Information or Assistance by Board Members 3) Approval of Board Policy 17-010 – Board Meeting Agenda Development, Efficiency of and Time Limits for Board Meetings, Role and Powers of Chairperson 4) Approval of Board Policy 17-011 – Placement of Items on Committee Agendas 5) Approval of Board Policy 17-021 – Use of Legal Counsel by Members of the Board of Directors 6) Approval of Board Policy 17-022 – Maintenance of Confidentiality by Directors and Committee Members 7) Approval of Board Policy 17-023 – Responsibility for Decision-making on Legal Matters 8) Approval of Board Policy 17-042 – Duties of the Board of Directors 9) Approval of Board Policy 17-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms B) Approval of amended Bylaws C) Approval of Medical Staff Rules & Regulations 1) Department of Pediatrics 2) Department of Radiology **G. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 0 *(No meeting held in November, 2017)* (2) Minutes – Approval of: a) Regular Board of Directors Meeting – October 26, 2017 b) Special Board of Directors Meeting – November 2, 2017 c) Special Board of Directors Meeting – November 29, 2017 (Oceanside) d) Special Board of Directors Meeting – November 29, 2017 (Carlsbad) e) Special Board of Directors Meeting – November 30, 2017 (Vista) (3) Meetings and Conferences – NONE (4) Dues and Memberships - NONE		Audit, Comp. & Ethics Comm. Standard
23	Discussion of Items Pulled from Consent Agenda	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
24	Reports (Discussion by exception only) (a) Dashboard (b) Construction Report – None (c) Lease Report – (November, 2017) (d) Reimbursement Disclosure Report – (November, 2017) (e) Seminar/Conference Reports - None	0-5 min.	Standard
25	Legislative Update	5 min.	Standard
26	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
27	Additional Comments by Chief Executive Officer	5 min.	Standard
28	Board Communications (three minutes per Board member)	18 min.	Standard
29	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	3.5 hours	
30	Oral Announcement of Items to be Discussed During Closed Session		
31	Motion to Return to Closed Session (if needed)		
32	Open Session		
33	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
34	Adjournment		

AUDIT, COMPLIANCE & ETHICS COMMITTEE

MEETING DATES

2018

Time: 8:30-10:00 AM

Location: All meetings to be held in Assembly Room # 1

January 18, 2018

April 19, 2018

May 17, 2018

July 19, 2018

August 16, 2018

September 20, 2018

October 18, 2018

COMMUNITY HEALTHCARE& ALLIANCE COMMITTEE

MEETING DATES

2018

Time: 12:30-2:00 PM

Location: All meetings to be held in Assembly Room #3

January 18, 2018

February 15, 2017

March 15, 2017

April 19, 2017

May 17, 2017

June 21, 2017

July 19, 2017

August 16, 2017

September 20, 2017

October 18, 2017

No Meeting in November

No Meeting in December

FINANCE, OPERATIONS AND PLANNING

MEETING DATES

2018

Time: 12:30-3:30 PM

Location: All meetings to be held in Assembly Room # 2, *(exceptions noted below)*

January 16, 2018

February 13, 2018, **AR #3**

March 20, 2018

April 17, 2018

May 22, 2018

June 19, 2018

July 17, 2018

August 21, 2018

September 18, 2018

October 16, 2018

~~November 20, 2018~~ **CANCELLED**

December 4, 2018 *(1st Week of December)*, **AR #3**

GOVERNMENT & LEGISLATIVE COMMITTEE

MEETING DATES

2018

Time: 12:30-2:00 PM

Location: All meetings to be held in Assembly Room # 3

January 2, 2018

April 3, 2018

July 3, 2018

October 2, 2018

HUMAN RESOURCES COMMITTEE

MEETING DATES

2018

Time: 12:30-2:30 PM

Location: All meetings to be held in Assembly Room # 3

January 9, 2018

April 10, 2018

July 10, 2018

October 9, 2018

HR EMPLOYEE FIDUCIARY RETIREMENT SUBCOMMITTEE

MEETING DATES

2018

Time: 11:00 AM-12:30 PM

Location: All meetings to be held in Assembly Room # 3

January 9, 2018

April 10, 2018

July 10, 2018

October 9, 2018

PROFESSIONAL AFFAIRS COMMITTEE

MEETING DATES

2018

Time: 12:00-2:30 PM

Location: All meetings to be held in Assembly Room # 1

January 11, 2018

February 8, 2018

March 8, 2018

April 12, 2018

May 10, 2018

June 14 , 2018

July 12, 2018

August 9, 2018

September 13, 2018

October 11, 2018

November 8, 2018

December 13, 2018

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2018

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m. Closed Session to begin at 1:30 p.m. and again immediately following Open Session, if needed

- January 25, 2018 (Last Thursday)
- February 22, 2018 (Last Thursday)
- March 29, 2018 (Last Thursday)
- April 26, 2018 (Last Thursday)
- May 31, 2018 (Last Thursday)
- June 28, 2018 (Last Thursday)
- July 26, 2018 (Last Thursday)
- August 30, 2018 (Last Thursday)
- September 27, 2018 (Last Thursday)
- No meeting in October due to General Election
- November 8, 2018 (Thursday following General Election)
- December 13, 2018 (Second Thursday in December)

Special Board of Directors Meeting – May 1, 2018 – 1:00 p.m.
Strategic Planning Workshop (1)

Special Board of Directors Meeting – May 3, 2018 – 10:00 a.m.
Closed Session to review biennial quality reports

Special Board of Directors Meeting –May 29, 2018 – 1:00 p.m.
Strategic Planning Workshop (2)

Special Board of Directors Meeting – June 14, 2018 – 6:00 p.m.
Budget Workshop

Special Board of Directors Meeting –December 11, 2018 – 10:00 a.m.
Closed Session to review biennial quality reports

2018 Dates to Note:

- ACHD Leadership Academy – February 8-9, 2018
- CHA Legislative Day – March 20-21, 2018
- ACHD Legislative Day – TBD
- AHA Annual Meeting – May 6-9, 2018
- ACHD Annual Meeting – TBD

Proposed Schedule: December 14, 2017
Approved by BOD:

BOARD COMMITTEE RECOMMENDATIONS

Professional Affairs Committee

- No changes recommended.

Finance, Operations & Planning Committee

- Reduce community members to two (2)
- Add one primary care physician (to be appointed by Chief of Staff)
- Administrative Staff attendees to include General Counsel, Chief Compliance Officer, Chief Financial Officer, Chief Operations Officer, Chief Nurse Executive and Chief Executive Officer
- Focus on financial performance of the hospital and any critical areas that need attention.
- Implement Consent Calendar for all items that are not handled by "write-ups"; items can be pulled from Consent Calendar as necessary

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 7, 2017

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/15/2017 – 10/31/2019)

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 12/15/2017 through 10/31/2019:

- **FLORES, Edna MD (CCare)**
- **HOTCHKISS, John M.D. / Teleradiology (StatRad)**
- **KELLY, Thomas MD/Maternal & Fetal Medicine (UCSD)**
- **WILSON, Deisha DO/Family Medicine (OptumCare)**
- **WOLF, Richard DO/Maternal & Fetal Medicine (UCSD)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 3
November 7, 2017

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2018 -12/31/2019)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2018 through 12/31/2019, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **BANSAL, Preeti MD/ Ophthalmology/Provisional**
- **BREESE, Mark DMD/ Oral & Maxillofacial Surgery/Provisional**
- **BROWN, Dorothy MD/ Emergency Medicine/Active**
- **CIZMAR, Branislav MD/ OB/GYN/Provisional**
- **DANG, Paul MD/Internal Medicine/Active**
- **GUALBERTO, Gary MD/Neurology/Provisional**
- **KARAS, Stephen MD/ Emergency Medicine/Active**
- **LEVINE, Neil MD/Internal Medicine/Refer and Follow**
- **MALHIS, Safouh MD/Pulmonary Medicine/Active**
- **MATAYOSHI, Amy MD/Internal Medicine/Active**
- **PATEL, Sanketkumar MD/Internal Medicine/Active**
- **SORKHI, Ramin/General & Vascular Surgery/Active Affiliate**
- **ZAVERI, Maulik MD/Ophthalmology/Active**
- **ZORRILLA, Juan MD/ Emergency Medicine/Active**

UPDATE TO PREVIOUS REAPPOINTMENT:

- **MOZAYAN-ISFAHANI, Arash /Active Affiliate**

Attachment B

RESIGNATIONS: (Effective date 12/31/2017 unless otherwise noted)

Automatic:

- CHAMMAS, Joseph MD

Voluntary:

- LUDEMAN, Lori MD/Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 7, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 12/15/17, unless otherwise specified)

• **GRANT, Colette MD** Release from Proctoring:	**Pediatrics** Newborn Care Level 1 & 2, Amit Patients Level 1 & 2, Performance of History & Physical, Consultation
• **KROENER, John MD** Release from Proctoring:	**General Surgery** Assist in Robotic Surgery (da Vinci) & Xi
• **MCGRAW, Charles MD** Release from Proctoring:	**Anesthesiology** Moderate Sedation
• **MOSTOFIAN, Eimaneh MD** Release from Proctoring:	**OB/GYN** Vaginal Deliveries & Diagnostic Laparoscopy
• **NOEL, Sophonie MD** Release from Proctoring:	**Anesthesiology** Consultation, Evaluate and treat patients with anesthesia related problems, Perform history and physical examination, General Anesthesia, Regional Anesthesia, Invasive Monitoring
• **PERLMAN, Tamara CNM** Release from Proctoring:	**Allied Health Professional** First Assist at C-Section
• **SILVERWOOD, Cristie NP** Release from Proctoring:	**Allied Health Professional** NP - Neurology
• **STABLER, Holly PAC** Release from Proctoring:	**Allied Health Professional** Central IV Access
• **TAYLOR, Phyllis NP** Release from Proctoring:	**Allied Health Professional** NP - Hospitalist
• **TOMENANG, Neil MD** Release from Proctoring:	**Emergency Medicine** Limited Abdominal Ultrasonography
• **TRULLENDER, Brett MD** Release from Proctoring:	**Emergency Medicine** General Patient Care
• **WILTSE, Lise MD** Release from Proctoring:	**Anesthesiology** Regional Anesthesia

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 7, 2017

Attachment C

PROCTORING RECOMMENDATIONS (Effective 12/15/17, unless otherwise specified)

• GRANT, Colette MD	Pediatrics
• KROENER, John MD	General Surgery
• MCGRAW, Charles MD	Anesthesiology
• MOSTOFIAN, Eimaneh MD	OB/GYN
• NOEL, Sophonie MD	Anesthesiology
• PERLMAN, Tamara CNM	Allied Health Professional
• SILVERWOOD, Cristie NP	Allied Health Professional
• STABLER, Holly PAC	Allied Health Professional
• TAYLOR, Phyllis NP	Allied Health Professional
• TOMENANG, Neil MD	Emergency Medicine
• TRULLENDER, Brett MD	Emergency Medicine
• WILTSE, Lise MD	Anesthesiology

Human Resources Committee
(No meeting held in November, 2017)

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

Community Healthcare & Alliance Committee (No meeting held in November, 2017)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
December 7, 2017

Members Present	Director Julie Nygaard, Director Cyril Kellett, Director Laura Mitchell, Dr. Marcus Contardo, Dr. Gene Ma, Dr. Mark Yamanaka, Steve Harrington, Wayne Lingenfelter
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Kapua Conley, COO, Carlos Cruz, CCO, Scott Livingstone, VP Hospital Transformation Officer, Susan Bond, Director-Legal Services
Others:	Jeremy Raimo, Chris Miechowski, Colleen Thompson, Glen Newhart, Jane Dunmeyer, David Bennett, Maria Carapia, Sarah Jayyousi, Charlene Carty, Mark Albright, Mary Diamond, Thomas Moore, Candice Parras, Steve Berner, Barbara Hainsworth
Members Absent:	None

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:36 p.m.		
2. Approval of Agenda		**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved to accept the agenda of December 7, 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 October 17, 2017	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, that the minutes of October 17, 2017 are to be approved, with Director Nygaard and Dr. Ma abstaining.**	
5. Old Business			

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
6. New Business			
a. Discussion: • Finance, Operations & Planning Committee Meeting: Structure, Membership and Meeting Frequency	Director Nygaard initiated the discussion. She emphasized the goal of any modifications made to the current structure would be to improve the overall efficiency of the Committee, and permit more in depth follow-up on the various programs and how they are performing. It was suggested that a consent calendar be implemented for renewal items. The structure of the voting and non-voting members would remain the same. It was recommended that there be two community members in lieu of the previous five. It was also suggested that a primary care physician be added to the medical staff member panel. The physicians on the Committee were asked to assist with the viability of this recommendation.		Chair
b. Co-Medical Director Agreement – Outpatient Behavioral health • Martina Klein, M.D.	Sarah Jayyousi explained that this is a new agreement with Dr. Martina Klein, who is replacing Dr. Mirow in the capacity of co-medical director for Outpatient Behavioral Health. Dr. Klein is projected to work four hours per week.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Dr. Martina Klein for Co-Medical Directorship for a term of 31 months, beginning December 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual maximum cost not to exceed $35,120,**	Sarah Jayyousi

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
		and a total cost for the term not to exceed $90,706.	
c. Rady Children's Specialists Agreement for NICU ROP Testing	Mary Diamond conveyed that this was a renewal agreement for ophthalmic consultation services in the NICU to screen for retinopathy of prematurity, with an increase in rate. Brief discussion ensued.	**MOTION** **It was moved by Director Kellett, Dr. Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2018, and ending December 31, 2018, for a cost of $3,077 per month, for a total cost for the term of $36,924.**	Mary Diamond
d. Premier Laser Services, Inc. Increase Proposal	Mary Diamond reported that this proposal is being submitted to increase the amount of the existing agreement with Premier Laser Services, Inc. She cited the increased use of certain devices, as well as a shift in use to the higher powered holmium laser as the sources for the increasing the amount.	**MOTION** **It was moved by Director Mitchell, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize an increase in term cost for the existing agreement with Premier Laser Services LLC, with a term beginning April 4, 2016 and ending April 3, 2018. The new not-to-exceed cost for the term is $525,000.**	Mary Diamond
e. Premier Laser Services, Inc. Proposal	Mary Diamond explained that this proposal for Premier Laser Services, Inc. was a contract renewal to provide equipment, supplies and technicians for rental surgical lasers, ultrasound, extracorporeal shock wave	**MOTION** **It was moved by Dr. Contardo, Director Kellett seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the**	Mary Diamond

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	lithotripsy (ESWL) and Cavitron ultrasonic surgical aspirator (CUSA) with no increase in rate.	**agreement with Premier Laser Services, Inc. for laser, ESWL (Extracorporeal Shock Wave Lithotripsy), ultrasound and CUSA (Cavitron Ultrasonic Surgical Aspirator) rental for a term of 24 months, beginning April 4, 2018 and ending April 3, 2020, for an annual cost of $275,000, and a total cost for the term of $550,000.**	
f. South Coast Perfusion, LLC Proposal	Mary Diamond conveyed that this agreement is a renewal for perfusion services with South Coast Perfusion, LLC, which includes an increase in rate.	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with South Coast Perfusion, LLC for Perfusion Services for a term of 24 months, beginning February 1, 2018 and ending January 31, 2020 for a total term cost not to exceed $350,000.**	Mary Diamond
g. Shared Marketing Agreement Proposal • Katherine Ludington, M.D., North Coast Cardiology	David Bennett communicated that this was a new agreement for shared marketing services between Tri-City Medical Center and Dr. Katherine Ludington. All shared marketing costs would be agreed upon and signed off by both parties before production, and each party agrees to split the costs 50/50. David clarified that the agreement would consist of a printed mailer distributed to residents of the District and the primary care	**MOTION** **It was moved by Director Kellett, Director Mitchell seconded, and it was approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the agreement with Katherine Ludington, M.D. for shared marketing services for a term of 12 months, beginning December 1, 2017 and ending November 30, 2018 for an annual cost of $8,000, and a total cost for the term of $8,000 ($4,000 for each entity), with Mr.**	David Bennett

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	physicians. Significant discussion ensued.	**Lingenfelter dissenting.**	
h. SonoCiné Room Addition to Women's Imaging Center Project • Good-Men Roofing & Construction, Inc.	Glen Newhart explained that the SonoCiné ultrasound is a significantly more accurate breast cancer detection tool, and used in adjunct to traditional mammography. He stated that this project would be fully funded by the Tri-City Hospital Foundation. Chris Miechowski conveyed that Good-Men Roofing and Construction Company was the lowest responsive bidder for the project. Once begun, the project could be completed in 4-6 weeks.	**MOTION** **It was moved by Director Mitchell, Dr. Contardo 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 construction costs of $124,263 and the total expected project cost of $257,082 for addition of the new SonoCiné Room in the Women's Imaging Center.**	Chris Miechowski
i. Enterprise Dragon Dictation Proposal	Mark Albright conveyed that this is a new agreement with Enterprise Dragon for voice recognition technology which would permit dictation of medical notes directly into the electronic medical record (EMR) in "real-time", thus enhancing communication between clinicians, while increasing patient safety and physician satisfaction. Significant discussion ensued. Director Nygaard requested Mark Albright return to give the Committee an update on this proposal, two months after the initial roll out.	**MOTION** **It was moved by Dr. Contardo, 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 Cerner for Enterprise Dragon for a term of 60 months, beginning January 1, 2018 and ending December 31, 2022 for an annual cost of $302,950, and a total cost for the term of $1,514,752.**	Mark Albright
j. Carlsbad-Wellness Center MOB Lease Agreement	Jeremy Raimo explained that this is a new agreement for a revenue	**MOTION** **It was moved by Director Mitchell, Dr.**	Jeremy Raimo

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
Proposal	generating, 10 year lease of suite 200 at the Carlsbad-Wellness medical office building to Lansara, a California corporation dba Dermacare. He further conveyed that the tenant improvements required are not to exceed $269,037. Brief discussion ensued.	**Contardo seconded, and it was unanimously approved that the Finance, Operations and Planning Committee recommend that the TCHD Board of Directors authorize the Lease Agreement for Suite 200 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Lansara, Inc. for a ten-year term (120 Months), at the rate of $7,786.50 per month for the first year, increasing 3% yearly thereafter, and also tenant improvement costs of $269,037 for Suite 200 in the Carlsbad Wellness Center MOB.**	
k. Financials	Ray Rivas presented the financials ending October 31, 2017 (dollars in thousands) **TCHD – Financial Summary** **Fiscal Year to Date** Operating Revenue $ 121,365 Operating Expense $ 124,270 EBITDA $ 3,999 EROE $ (1,219) **TCMC – Key Indicators** **Fiscal Year to Date** Avg. Daily Census 172 Adjusted Patient Days 37,921 Surgery Cases 2,208 Deliveries 832 ED Visits 21,167 **TCHD – Financial Summary** **Current Month** Operating Revenue $ 31,312 Operating Expense $ 31,896		Ray Rivas

Topic	Discussions, Conclusions & Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
	EBITDA $ 1,146 EROE $ (171) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 173 Adjusted Patient Days 9,689 Surgery Cases 564 Deliveries 206 ED Visits 5,177 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 45.8 Days in Net A/R Avg. 48.8 **Graphs:** • TCMC-Net Days in Patient Accounts Receivable • TCMC-Adjusted Patient Days • TCMC-Acute Average Length of Stay		
I. Work Plan – Information Only • ED Throughput	Candice Parras gave a brief PowerPoint presentation detailing the significant improvement in ED wait times, as well as the "left without being seen" (LWBS) patient population. She sighted these improvements as the source for an increase in overall ED patient satisfaction. Also mentioned was the implementation of designated beds for patients arriving via paramedic, as well as the institution of the ED "zoomer nurse" to expedite patient flow.		Candice Parras

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
• Dashboard	No Discussion Additionally, Director Nygaard suggested and the Committee agreed to a change in the reporting structure of the following Work Plan items: • Crisis Stabilization Unit (CSU) – Reporting would be changed from semi-annually to every other month • Medical Director, Surgery – Reporting would be modified from quarterly to semi-annually		Ray Rivas
7. Comments by committee members	Mr. Lingenfelter took this opportunity to convey that he'd had a recent stay at Tri-City Medical Center and praised the hospital staff for ensuring his stay was extremely positive.		
8. Date of next meeting	Tuesday, January 16, 2018		Chair
9. Community Openings (3)			
10. Adjournment	Meeting adjourned 1:42 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
Co-Medical Director Agreement - Outpatient Behavioral Health

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

Physician Name: Martina Klein, M.D.

Area of Service: Outpatient Behavioral Health

Term of Agreement: 31 months, Beginning, December 1, 2017 – Ending, June 30, 2020

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

Hourly Cost	Monthly Cost	Annual Cost	Total Term Cost
$140 / 4 Hours/week	$2,426	$29,120	$75,206
	$500 Vacation Coverage	$6,000 Vacation Coverage	$15,500 Vacation Coverage
	Total: $2,926	**Total: $35,120**	**Total: $90,706**

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

escription of Services/Supplies:

- Agreement replaces Dr. Mirow's Agreement
- Provide professional guidance and oversight for the Outpatient Behavioral Health department, including, the Intensive Outpatient and Older Adult Program.
- Provide supervision for the clinical operation of the department and programs.
- Provide patient and staff education and educate providers and community members on availability of efficacy of Intensive outpatient Program services.
- Respond to insurance authorization calls and complete reports requested by patients
- Facilitate weekly treatment team meetings and evaluate appropriateness for continued stay.

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: Sarah Jayyousi, Operations Manager, Outpatient Behavioral Health / Sharon Schultz, Chief Nurse Executive

otion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Dr. Martina Klein for Co-Medical Directorship for a term of 31 months, beginning December 1, 2017 and ending June 30, 2020 for an hourly rate of $140, an annual maximum cost not to exceed $35,120, and a total cost for the term not to exceed $90,706.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
Rady Children's Specialists Agreement for NICU ROP Testing

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

Vendor's Name: Rady Children's Specialists of San Diego

Area of Service: NICU - Retinopathy of Prematurity Testing

Term of Agreement: 12 months, Beginning, January 1, 2018 - Ending, December 31, 2018

Maximum Totals:

	Monthly Cost	Annual Cost	Total Term Cost
ROP Services	$3,077	$36,924	$36,924
		Total:	**$36,924**

Description of Services/Supplies:

- Ophthalmic Consultation Services for NICU - Retinopathy of Prematurity (ROP) Testing
- Requested increase of $324 per month, $3,888 for the term

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

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 agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity Testing for a term of 12 months, beginning January 1, 2018, and ending December 31, 2018, for a cost of $3,077 per month, for a total cost for the term of $36,924.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
PREMIER LASER SERVICES, INC. INCREASE PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other: Increase in Term Cost
Status of Agreement		New Agreement		Renewal – New Rates		Renewal – Same Rates

Vendor's Name: Premier Laser, Inc.

Area of Service: Surgery

Term of Agreement: 24 months, Beginning, April 4, 2016 – Ending, April 3, 2018

Maximum Totals:

Total Term Cost Not to Exceed
$525,000

Description of Services/Supplies:

- Requesting an additional $155,496 to be added to the existing contract with Premier Laser Service, LLC. The current approved term spend for this vendor is $369,504.
- Spend in 2016 (January –December) was $262,048, budgeted spend was $184,752
- Spend 2017 (January –May) is $89,860, at this rate, 2017 spend will be $215,664
    - Increased use of BK Ultrasound device for robotic/laparoscopic partial nephrectomy
    - Increased use of the Power Wand for PNCL cases
    - Shift in use to higher powered holmium laser

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: Original Cost ($369,504)	X	Yes		No
Budgeted Item: Additional Cost ($155,496)	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 an increase in term cost for the existing agreement with Premier Laser Services LLC, with a term beginning April 4, 2016 and ending April 3, 2018. The new not-to-exceed cost for the term is $525,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
PREMIER LASER SERVICES, INC. PROPOSAL

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

Vendor's Name: Premier Laser Services, Inc.

Area of Service: Surgical Services

Term of Agreement: 24 months, Beginning, April 4, 2018 – Ending, April 3, 2020

Maximum Totals:

Annual Cost	Total Term Cost
$275,000	$550,000

Description of Services/Supplies:

- Equipment, supplies and technicians for rental surgical lasers, ultrasound, ESWL (Extracorporeal Shock Wave Lithotripsy) and CUSA (Cavitron Ultrasonic Surgical Aspirator).
- Contracting for these services provides for the most up to date equipment and supplies, availability of qualified personnel to operate the equipment and avoidance of costs associate with the purchase, maintenance, repair, supplies and staffing.

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.*
***To be included in the next proposed FY Budget*

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 agreement with Premier Laser Services, Inc. for laser, ESWL (Extracorporeal Shock Wave Lithotripsy), ultrasound and CUSA (Cavitron Ultrasonic Surgical Aspirator) rental for a term of 24 months, beginning April 4, 2018 and ending April 3, 2020, for an annual cost of $275,000, and a total cost for the term of $550,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
SOUTH COAST PERFUSION, LLC PROPOSAL

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

Vendor's Name: South Coast Perfusion, LLC

Area of Service: Surgery

Term of Agreement: 24 months, Beginning, February 1, 2018 – Ending, January 31, 2020

Maximum Totals:

Total Term Cost Not to Exceed
$350,000

Description of Services/Supplies:

- Cardiopulmonary Bypass (CPB)/Standby for cardiac cases
- IntraAortic Balloon Pump Support
- Ventricular Assist Device Support
- ECMO/CPS Support
- Autotransfuion
- Inter-facility Transport
- Hourly rate of $150 for CPB beyond 5 hours
- 5% Rate Increase, as of March 2019

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: 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 agreement with South Coast Perfusion, LLC for Perfusion Services for a term of 24 months, beginning February 1, 2018 and ending January 31, 2020 for a total term cost not to exceed $350,000.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
Shared Marketing Agreement Proposal

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

Vendor's Name: Katherine Ludington M.D.

Area of Service: North Coast Cardiology

Term of Agreement: 12 months, Beginning, December 1, 2017 – Ending, November 30, 2018

Maximum Totals:

Average TCMC Monthly Cost	**TCMC Total Term Cost**
$333.50	$4,000
Average Monthly Cost	**Total Term Cost**
$667.00	$8,000 ($4,000 for each entity)

Description of Services/Supplies:

- Shared activities, where each party agrees to 50/50 split of marketing costs. All shared marketing costs will be agreed upon and signed off in writing by both entities before production and may include: Billboards, TV commercials, radio, social media, print ads, mailings, banners, buses, digital ads, events, co-branded promotional materials and photos.

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: David M. Bennett, Chief Marketing Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Katherine Ludington, M.D. for shared marketing services for a term of 12 months, beginning December 1, 2017 and ending November 30, 2018 for an annual cost of $8,000, and a total cost for the term of $8,000 ($4,000 for each entity).

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
SONOCINÉ ROOM ADDITION TO WOMEN'S IMAGING CENTER PROJECT

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

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

Area of Service: Women's Imaging Center

Term of Agreement: Completion of work

Maximum Totals:

Room Addition Proposal:	**Total Expected Cost:**
Good-Men (Construction)	$124,263
Design, Permits, Inspections, Nurse Call, Contingency	$132,819
Total Expected Project Cost	**$257,082**

Description of Services/Supplies:

- Project is fully funded by the Foundation.
- Good-Men Roofing & Construction, Inc. was the lowest responsive bidder. Bid results below:

Company:	**Bid Amount:**
Good-Men	$124,263
Jennette	$124,700

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 & Construction, Inc. for construction costs of $124,263 and the total expected project cost of $257,082 for addition of the new SonoCiné Room in the Women's Imaging Center.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
Enterprise Dragon Dictation Proposal

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

Vendor's Name: Nuance Enterprise 360 Medical Dragon purchased through Cerner
Area of Service: Medical Staff
Term of Agreement: 60 months, Beginning, January 1, 2018 – Ending, December 31, 2022

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$25,245	$302,950	$1,514,752

Description of Services/Supplies:

- Cerner Enterprise Dragon is a voice recognition technology that allows providers to dictate medical notes directly into the EMR "real-time." The utilization of this technology has become industry standard in both physician practices and hospitals across the county.
- Because the notes are populated "real-time" it enhances communication between clinicians increasing patient safety and physician satisfaction. Credentialed physicians will be able to utilize a smart phone application to dictate remotely.
- The technology enhances revenue cycle better supporting documentation flow, decision support and compliance.
- The proposal includes remote hosting (cloud), Dragon training, and maintenance/support

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, Vice President, Information Technology / Kapua Conley, Chief Operating Officer

Motion:

I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Cerner for Enterprise Dragon for a term of 60 months, beginning January 1, 2018 and ending December 31, 2022 for an annual cost of $302,950, and a total cost for the term of $1,514,752.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 7, 2017
Carlsbad-Wellness Center MOB Lease Agreement Proposal

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

Tenant Name: Lansara, Inc., a California Corporation dba Dermacare ("Tenant")

Term: 10 Year Lease (July 1, 2018 thru June 30, 2028), or
Commencement Date at completion of tenant improvements
3% Yearly Rent Escalator; Option for two, three year extensions at FMV

Premises: 6260 El Camino Real, Suite 200, Carlsbad, CA 92009 (2,685 sq. ft.)

Rental Rate from Lansara, Inc.:

Rental Rate from Lansara, Inc.:	**Revenue per Month**
Rental Rate of $2.90 NNN per square foot, per month, (2685 sq. ft.)	$7,786.50
Total Monthly Revenue:	**$7,786.50**

Expense to Tri-City Healthcare District:

District ("Landlord) to Provide:	**Cost Not to Exceed**
Tenant Improvement Allowance of $100 per square foot per rentable area, (2685 sq. ft.) =	$268,500
Space Planning Fee of $0.20 per square foot =	$537
Total Expense:	**$269,037**

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

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director, Business Development / Steve Dietlin, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the Lease Agreement for Suite 200 in the Carlsbad Wellness Center MOB located at 6260 El Camino Real, Carlsbad, CA 92009, with Lansara, Inc. for a ten-year term (120 Months), at the rate of $7,786.50 per month for the first year, increasing 3% yearly thereafter, and also tenant improvement costs of $269,037 for Suite 200 in the Carlsbad Wellness Center MOB.

DRAFT

Tri-City Medical Center
Professional Affairs Committee Meeting
Open Session Minutes
November 09, 2017

Members Present: Director Laura Mitchell (Chair), Director Jim Dagostino, 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, Susan Bond, Director of Legal Services Marcia Cavanaugh, Sr. Director for Risk Management and Jami Piearson, Director of Quality and Regulatory.

Others Present: Priscilla Reynolds, Kathy Topp, Sharon Davies, Merebeth Richins, Stephen Chavez-Matzel, Chris Miechowski, Oska Lawrence, Jeff Surowiec, Patricia Guerra and Karren Hertz.

Members Absent: None.

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
1. Call To Order	Director Mitchell called the meeting to order at 12:06 PM in Assembly Room 1.		Director Mitchell
2. Approval of Agenda	The committee reviewed the agenda; there were no additions or modifications.	Motion to approve the agenda was made by Director Dagostino 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 October 2017.	Director Mitchell called for a motion to approve the minutes from October 12, 2017 meeting.	The minutes were ratified and was approved by the group. Director Dagostino moved and Dr. Contardo seconded the motion to approve the minutes from October 2017.	Karren Hertz
5. New Business a. Consideration and Possible Approval of Policies and Procedures **Patient Care Policies and Procedures** 1. Code Pink in Women's and Children's Services Standardized Procedure	There was a clarification made between Code Pink and Code Caleb. Code Caleb is called for newborns from birth to 30 days old babies while Code Pink applies to pediatric patients specifically from ages 31 day-old babies to 14 year-old patients.	**ACTION:** The Patient Care policies and procedures were approved. Director Dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
2. End of Life Policy	It was noted that Tri-City does not participate in the End of Life Option Act program. Director Grass inquired about the mental health evaluation for end of life patients which the hospital does not really practice. There was also a brief discussion on this policy as a state requirement and role of the PCP in complying with this policy.		
3. Monitor Technicians(MTs): Communication Process	It was stated that the binder strips are in another policy. Policy on management of		

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	ECG strips will be added to this policy as a related document.		
4. Newborn Screening Collection of Specimen Procedure	The committee made a recommendation to use the new forms for the newborn screening collection.		
5. Pet Therapy Policy	A clarification was made that only a verbal permission is needed if a dog can be allowed in a patient's room. There was also a recommendation to add influenza shot on the dog handler's requirement.		
6. Pre-Printed Orders Policy	There was no discussion on this policy.		
7. Referrals to Social Services for patients Identified to be High Risk Policy	Director Mitchell made a clarification that surrogacy is not considered an adoption. Surrogacy was made as a separate line item. Attempted suicide is not an automatic high-risk for Social Workers because the Behavioral Health unit has its own social worker. Patient does not need to talk but the Social Worker has to offer high risk patient counselling and support.		
Unit Specific **Behavioral Health Services** 1. Administration of Antipsychotic Medication	This policy will be approced for now and will come back as a PCS policy to include the	**ACTION:** The Behavioral Health policy was approved. Dr. Souza	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
	inpatient population. Joy also mentioned that the if the patient is involuntary then he/she does not need a consent order. They can consent on their own to anti-psychotic medication. The consent to receive psychotropic medication was also added to this policy.	moved and Director Dagostino seconded the motion to approve the policies moving forward for Board approval.	
Engineering 1. Utility Management Plan 4003	Jeff Surowiec stated that this policy is a Joint Commission requirement.	**ACTION:** The Engineering policy was approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Dagostino.	Patricia Guerra
Environment of Care 1. Life Safety Management Plan 2. Safety Plan 3. Security Management Plan	Jeff Surowiec explained to the committee that there are different levels of EOC that is why all the management plans have to be differentiated from one another. There was a recommendation to add in active shooter information to this policy.	**ACTION:** The Environment of care policies were approved. Director dagostino moved and Dr. Souza seconded the motion to approve the policies moving forward for Board approval.	Patricia Guerra
Outpatient Behavioral Health 1. Transportation of Patients	There is no discussion on this policy.	**ACTION:** The Outpatient behavioral health policy was approved to move forward to Board approval as moved by Dr. Souza and seconded by Director Dagostino.	Patricia Guerra
Rehabilitation 1. Pet Therapy- Tender Loving Canines	There was no discussion on this policy.	**ACTION:** The Rehabilitation policy was approved to move	Patricia Guerra

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
		forward to Board approval as moved by Dr. Souza and seconded by Director Dagostino.	
6. Review and Discussion: • Frequency of Meetings • Scope of meetings • PAC Charter	The core of the hospital business is patient care. The committee's main objective is to discuss and review professional affairs and quality as it relates to patient care. In line with this objective, the group discussed that all the policies and procedures related to patient care has to go to a governing body (Board of Directors). All of the policies change due to current TCMC structure so it will be beneficial for this group to still meet once a month in order to keep up with the changes and modifications.	**ACTION:** The PAC Committee made a recommendation to retain its original schedule moving forward to the next year.	Director Mitchell
7. Closed Session	Director Mitchell asked for a motion to go into Closed Session.	Director Dagostino moved, Dr. Johnson seconded and it was unanimously approved to go into closed session at 1:10 PM.	Director Mitchell
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

Topic	Discussion	Follow-Up Action/ Recommendations	Person(s) Responsible
11. Adjournment	Meeting adjourned at 2:05 PM.		Director Mitchell

PROFESSIONAL AFFAIRS COMMITTEE
November 9, 2017

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services		
1. Code Pink In Women's And Children's Services Standardized Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
2. End of Life Policy	Practice Change	Forward to BOD for Approval
3. Monitor Technicians (MTs): Communication Process	NEW	Forward to BOD for Approval with Revisions
4. Newborn Screening Collection of Specimen Procedure	3 Year Review, Practice Change	Forward to BOD for Approval
5. Pet Therapy Policy	Practice Change	Forward to BOD for Approval with Revisions
6. Pre-Printed Orders Policy	3 Year Review, Practice Change	Forward to BOD for Approval
7. Referrals to Social Services for Patients Identified to be of High Risk Policy	3 Year Review, Practice Change	Forward to BOD for Approval with Revisions
8. Venipuncture for Specimen Collection Procedure – **Tracked Changes** Venipuncture for Specimen Collection Procedure – **Clean Copy**	3 Year Review, Practice Change	Approved at 10/12/17 PAC Forward to BOD for Approval with Revisions
Unit Specific		
Behavioral Health Services		
1. Administration of Antipsychotic Medication	3 Year Review	Forward to BOD for Approval with Revisions
Engineering		
1. Utility Management Plan 4003	Practice Change	Forward to BOD for Approval
Environment of Care		
1. Life Safety Management Plan	Practice Change	Forward to BOD for Approval
2. Safety Plan	Practice Change	Forward to BOD for Approval
3. Security Management Plan	Practice Change	Forward to BOD for Approval with Revisions
Outpatient Behavioral Health		
1. Transportation of Patients	DELETE	Forward to BOD for Approval
Rehabilitation		
1. Pet Therapy Tender Loving Canines 903	DELETE	Forward to BOD for Approval
Formulary Requests		
1. Colloidal Oatmeal	DELETE	Forward to BOD for Approval
2. Dicyclomine Vial for Injection	DELETE	Forward to BOD for Approval
3. Fentanyl Lozenges	DELETE	Forward to BOD for Approval
4. Lactase Enzyme Tablets	DELETE	Forward to BOD for Approval

STANDARDIZED PROCEDURE: CODE CALEB~~PINK IN WOMEN'S AND CHILDREN'S SERVICES~~

A. **POLICY:**

1. Function:
   - **a.** Management of cardiopulmonary arrest in the **infant**~~neonate~~ **~~and~~ up to 30 days old~~of life~~** following Neonatal Resuscitation Program (NRP) guidelines **when event occurs on the Labor and Delivery (L&D) Unit, Mother-Baby Unit and Neonatal Intensive Care Unit (NICU). NRP and/~~or Pediatric~~or Pediatric Advanced Life ~~Support~~ (Support (PALS) guidelines shall be ~~utilized when~~utilized when event occurs in the Emergency Department (ED) and any other location on the hospital campus based on responder training. A Code Caleb shall be called for any infant up to 30 days old in need of resuscitation and stabilization within the institution, surrounding grounds and unexpectedly upon arrival in the ED.**

2. Circumstances:
   - a. Setting: ~~Labor and Delivery (L&D), Postpartum, Nursery and Neonatal Intensive Care Unit (NICU) Emergency Department, and any location on the hospital campus.~~ **Tri-City Medical Center**
   - b. Supervision: None required. The standardized procedure shall be implemented and the attending physician shall be notified immediately. Upon arrival, the physician assumes responsibility in directing the resuscitation.
   - **c.** Patient contraindications: ~~Patients with a written "no code" order.~~**None**

~~**A CODE CALEB shall be called for any infant up to 30 days oldof life in need of resuscitation and stabilization within the institution, surrounding grounds** and **unexpectedly upon arrival in the ED.**~~

3. **Data Base:**
   - **a. The initial steps of infant resuscitation shall be provided within a few seconds and include: Providing warmth, positioning the infant on a back, side or sniffing position and drying and stimulating the infant. Resuscitation efforts shall be implemented when:**
   - **b. Objective: Infant is apneic, gasping, ineffectively breathing, the heart rate (HR) is less than 100, and/or infant is unresponsive to stimulation**
   - **c. Diagnosis: Life threatening emergency**
   - **d. Plan: Initiate a Code Caleb by dialing 66 on the telephone, implement the Standardized Procedure as appropriate, and notify the attending physician/ neonatologist**
   - **e. Assessment: Infant will be reassessed after each intervention.**
   - **f. Record Keeping: Events are to be recorded on the Neonatal Resuscitation Record and in the patient's electronic medical record.**
   - ~~a. **isup to** ,tons:~~

~~B. **INITIATING CODE CALEBPINK IN LABOR & DELIVERY, NURSERY, AND POSTPARTUM:**~~

~~1. First Responder:~~

~~a. Moves infant to radiant warmer for resuscitation, if infant is not on a radiant warmer.~~

~~i. In **Postpartum/ 2 S Overflow**, begins infant Cardiopulmonary Resuscitation (CPR) and anticipates transport to the high-care warmer in the treatment room.~~

Department Review	Clinical Policies & Procedures	Pharmacy and Therapeutics	Nurse Executive Council	Perinatal Collaborative Practice~~Divisi on of Neonatolgy~~	Department of Pediatrics	Inter-disciplinary Committee	Medical Executive Committee	Professional Affairs Committee	Board of Directors
11/07, 11/09, 09/12, 09/14	12/07, 11/09, 09/14, 11/16	02/08, 12/09, 09/14, 11/16	01/08, 12/09,10/14, 01/17	12/15, 04/17	05/16, 05/17	02/08, 12/09, 07/17	02/08, 02/10, 10/17	11/17	02/08, 02/10

~~b. Calls for assistance.~~
~~i. Begins ventilating infant per NRP guidelines.~~

~~2. Second responder:~~
~~a. Initiates Code **Caleb**Pink by dialing 66 on the telephone.~~
~~i. The operator shall announce "Code **Caleb**Pink" and the location over the P.A. System three times.~~
~~b. Assists with CPR per NRP guidelines.~~

~~3. NICU Team:~~
~~a. Responsible for bringing neonatal code cart.~~
~~b. Administers medications per NRP guidelines~~

~~4. Respiratory Care Practitioner~~(~~Respiratory Care Practitioners **assigned to the NICU**)who have completed the approved intubation training program and are competency validated respond.)~~
~~a. Provides airway management~~
~~b. Assists with compressions~~
~~c. **Assists with** Performs endotracheal intubation~~

~~5. Shift Supervisor/Relief Charge Nurse:~~
~~a. Ensures appropriate paperwork is completed on neonatal code sheet.~~
~~b. Ensures medication drawer of code cart is locked at the end of the code.~~

B. **PROCEDURE (INFANTS UP TO 30 DAYS OLD~~Children 30 days or less)~~ UTILIZING NRP GUIDELINES):**

~~1. Data Base:~~
~~a. The initial steps of infant resuscitation shall be provided within a few seconds and include: Providing warmth, positioning the infant on a back, side or sniffing position and drying and stimulating the infant.Resuscitation efforts shall be implementedwhen:~~
~~b. Objective:Infant is apneic, gasping , ineffectively breathing, the heart rate(HR) is less than 100, and/or infant is unresponsive to stimulation~~
~~c. Diagnosis- Life threatening emergency~~
~~d. Plan:.~~
~~i. Initiate a Code CALEB by dialing66 on the telephone, implementthe Standardized Procedure as appropriate, and notify the attending physician/ neonatologist~~
~~ii. **Assessment:** Infant **will be reassessed after each intervention.**~~
~~**Record Keeping: Events are to be recorded on the Neonatal ResuscitationRecord** and in the patient's electronic medical record..~~

~~A. Meconium Stained Amniotic Fluid~~
~~1. If infant is born VIGOROUS (strong respiratory efforts, good muscle tone HR greater than 100):~~
~~a. Clear mouth and nose of secretions, dry, stimulate, and reposition infant.~~
~~2. For NON-VIGOROUS infant (depressed respirations, depressed muscle tone and/or has HR less below 100):~~
~~a. Direct suctioning of the trachea soon after delivery is indicated by qualified staff- get equipment ready as indicated and avoid stimulation until after intubation and suctioning is completed.~~

~~2.~~**1. Respiratory Distress/Arrest:**

a. If infant is unresponsive to tactile stimulation (drying, back rub, foot flick, bulb syringe suction) provide positive pressure ventilation (PPV) per NRP guidelines at a rate of 40-60 breaths per minute (slightly less than once a second).
b. Apply a pulse oximeter to infant's right hand/wrist.
   i. During resuscitation efforts **immediately after birth,** the infant's oxygen saturation level ~~, based on age in minutes,~~ shall direct the titration of the oxygen percent required to achieve infant target oxygen saturation ranges listed in the "Targeted Pre-ductal Spo2 after Birth" Table.
      1) Term gestations: NRP suggests beginning at 21% oxygen level and

adjust concentration based on clinical condition.

2) Preterm infant consideration: start initial PPV with oxygen blended at **3400**%.

3) Spo2 range should be between 85% and 95% by 10 minutes of life

ii. For resuscitation not immediately following birth, may begin PPV oxygen concentration at 100% and reduce rate to achieve oxygen saturation ranges greater than 90%

c. If the HR is less than 100 bpm, take ventilation corrective steps: adjust mask, reposition head, suction mouth and nose, open mouth, increase ventilation pressure and/or use an alternate airway.

d. If there is no improvement with PPV, consider endotracheal intubation.

e. If the heart rate increases to greater than 100 and/or there are spontaneous respirations, begin post resuscitation care.

~~3.~~**2.** Bradycardia (HR less than 60):

a. If the HR is less than 60, after a minimum of 30 seconds of PPV, initiate chest compressions at a ratio of 3:1(compressions: ventilation).

b. Increase oxygen concentration to100% if not already done

c. Assist ~~Respiratory Care Practitioner (RCP) and/or~~ Neonatologist with endotracheal (ET) intubation and /or umbilical venous catheter (UVC) line placement. ~~,~~

~~6.~~**d.** If the heart rate remains below 60, consider EPINEPHRINE administration:

i. **Endotracheal** (ET) **dosing: 0.5mL/kg ~~(1:10,000 Concentration)~~ (0.1 mg/mL Concentration)**

1) **Administer every 3-5 minutes.**

ii. **Intravenous (IV)/ Intraosseous (IO) dosing: 0.1 mL/ kg ~~(1:10,000 Concentration)~~ (0.1 mg/ml Concentration)**

1) **Administer every 3-5 minutes via rapid intravenous push (IVP).~~:~~**

~~4.~~**3.** Prematurity (-Gestational age less than 35 6/7 weeks):

a. Protect from heat loss: Radiant warmer, heated towels, portable warming mattress, hat

i. If less than **32~~29~~** weeks consider polyethylene plastic wrap

b. May begin PPV at **34~~00~~%** oxygen concentration , initially if required

c. May benefit from continuous positive airway pressure (CPAP)

~~5.~~**4.** Hypovolemia (-Risk factors, pale, poor perfusion, oxygen saturation ratings less than 90%):

a. Start intravenous (IV) line

b. Assist Neonatologist with UVC line placement

c. Administer IV fluid bolus **10 mL/kg normal saline bolus slow IVP over 5 minutes- 10 minutes.**

~~6.~~**5.** Hypoglycemia:

a. **Obtain bedside capillary or arterial glucose. If** blood **glucose** level **is less than 45 mg/dL** and infant symptomatic, start IV line and/or assist the Neonatologist with UVC line placement.

~~7.~~**b.** ~~b.~~ Administer **D10 bolus: 2 mL/kg slow IVP.** ~~Refer to Newborn Hypoglycemia (Symptomatic) Management Standardized Procedure.~~

C. PROCEDURE (INFANTS UP TO 30 DAYS OLD ~~CHILDREN AGED 30 DAYS OR LESS~~ UTILIZING PALS GUIDELINES)~~[adjusted gestational age]~~):

~~**Data Base:**~~

~~**Subjective: None**~~

~~**Objective: Apnea or gasping/ineffective respirations and/or HR less than100 bpm.**~~

~~**Diagnosis: Bradycardia, cardiopulmonary arrest, or respiratory distress/arrest at delivery or within the neonatal period.**~~

~~**Plan:**~~

~~i. Initiate a Code CALEB by dialing66 on the telephone, implementthe Standardized Procedure as appropriate, and notify the attending physician/ neonatologist..~~

~~Assessment: Patient will be reassessed after each intervention.~~
~~Record Keeping: Events are to be recorded on the Neonatal ResuscitationRecord~~ and in the patient's electronic medical record..

1. **Respiratory Distress/Arrest:**
   - a. **Provide warmth.**
   - b. **Establish patent airway.**
   - c. **Position supine with head in neutral or slightly extended position.**
   - d. **S~~Adequate s~~uction PRN for secretions**
   - e. **Oxygen administration and positive pressure ventilations (PPV), if needed.**
   - f. **Assist with intubation as appropriate.**
   - g. **Obtain STAT Arterial Blood Gas (ABG) and chest x-ray as needed.**
2. **Heart rate less than 60 beats per minute (bpm) (Bradycardia):**
   - a. **Initiate compressions.**
   - b. **Begin bag/mask ventilation with 100% oxygen.**
   - c. **Establish venous access with Normal Saline (NS) flush.**
     - ~~ii.~~i. **Establish ~~intravenous~~(IV) access with NS at TKO rate (to be used for resuscitation medications or fluids as necessary). Consider ~~Intraosseous~~ (IO); umbilical vein pending arrival of neonatologist. .**
     - ~~iii.~~ii. **If hypovolemia suspected (~~-~~blood loss history, poor perfusion, pale, weak pulse) administer IV fluids of NS at 10 mL/kg slow Intravenous push (IVP) over 5-10 minutes.**
   - ~~b.~~d. **Medications for Bradycardia:**
     - i. **Epinephrine**
       1) **Indicated when heart rate remains less than 60 bpm despite 30 seconds PPV~~n~~ and another 30 seconds of coordinated compressions and ventilations.**
       2) **Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.**
       3) **Endotracheal dosing: ~~(~~0.5mL/kg ~~of 1:10,000 concentration~~(0.1 mg/mL Concentration). Administer every 3 - 5 minutes during arrest until IV/IO access achieved, then begin first IV/IO dose.**
       4) **IV/IO dosing: ~~(~~0.1 mL/kg~~)~~ ~~of 1:10,000 concentration~~(0.1 mg/mL Concentration). Administer every 3 – 5 minutes during arrest, max IV/IO individual dose 1 mg.**
       5) **Rate of administration is rapid IVP.**
3. ~~7.~~**Symptomatic Hypoglycemia:**
   - a. **Obtain bedside capillary or arterial~~venous~~ glucose. If glucose < 45 mg/dl then treat with D10 W bolus IV/IO 2 mL/ kg slow IVP.**

~~C.~~D. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

1. Current California RN license.
2. Education:
   - a. Successful completion of N**RP**~~eonatal Resuscitation Program (NRP)~~ course **for staff in L&D, Mother Baby Unit & NICU** (with a current course completion card)~~.~~
   - ~~8.~~**b.** Successful completion of **PALS** course **for staff in the ED** (with a current course completion card).
3. ~~2.~~Experience: Initial job requirement
4. ~~3.~~Initial Evaluation: RN must be observed demonstrating successful skills in management of a neonatal resuscitative e**vent using NRP and/or PALS guidelines as appropriate.**~~ffort in NRP.~~
5. ~~4.~~Ongoing evaluation annually.

~~D.~~E. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

1. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.

2. Review every two years.

~~E.~~F. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

1. All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform Code ~~Pink In Women's and Children's Services~~ **Caleb** Standardized Procedure.

~~F.~~G. REFERENCES:

1. Neonatal Resuscitation Program Textbook, S**eventh**~~ixth~~ Edition. (201~~6~~4). American Academy of Pediatrics and American Heart Association

~~1.~~**2. Pediatric Advanced Life Support Textbook, (2011). American Heart Association and American Academy of Pediatrics**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/05 **SUBJECT:** End of Life (Comfort Care)

REVISION DATE: 01/06, 06/08, 10/10 **POLICY NUMBER:** IV.P.3

Department Review:	05/17
Clinical Policies and~~&~~ Procedures Committee Approval:	~~06/15~~06/17
Nurse Executive Committee Approval:	~~07/15~~07/17
Pharmacy and Therapeutics Approval:	n/a
Utilization Review Committee Approval:	~~11/15~~08/17
Medical Executive Committee Approval:	~~01/16~~10/17
Professional Affairs Committee Approval:	~~02/16~~11/17
Board of Directors Approval:	02/16

A. **PURPOSE:**

1. To provide interventions in caring for the dying patient that is directed toward maximizing comfort, maintaining dignity, and providing support for the patient/family/significant others.
2. To provide emotional, spiritual, and cultural support with respect for patient/family/significant others values and preferences.

B. POLICY:

1. Tri-City Healthcare District (TCHD) declines to participate in the End of Life Option Act (AB X2-15), which permits an adult with a terminal disease and the capacity to make health care decisions to request and be prescribed an aid-in-dying drug if specified conditions are met.

a. If the individual transfers care to a new health care provider, the individual may request a copy of his or her medical records per the Administrative Policy: Patient Access to Protected Health Information in the Designated Record Set - 516.

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

1. Assess for the following:
   a. Pain
   b. Other uncomfortable symptoms (e.g. nausea, restlessness, excess secretions, dyspnea)
   c. Patient/family awareness of prognosis
   d. Family expectations of treatment plan, including Do Not Resuscitate (DNR) order and evidence of patient wishes
   e. Patient/family coping and spiritual needs
2. Implement the following comfort measures:
   a. Pain management interventions:
      i. Administer adequate analgesia.
      ii. Administer other medications as ordered for restlessness symptoms, nausea, respiratory distress or pooling secretions.
   b. Obtain vital signs as needed.
      i. Avoid using automatic blood pressure machines if possible and do not leave cuff in place for long periods.
   c. Reposition patient as needed.
      i. If turning patient hinders comfort, reduce frequency of turning.
   d. Limit procedures to only those needed to enhance comfort.
   e. Provide frequent oral care.

f. Assess intravenous (IV) sites every shift.
   i. Avoid routine IV starts and restart IV only if access is needed, consider alternate routes.
g. Consider obtaining foley catheter order.
h. Avoid aggressive interventions for high temperatures such as cooling blankets and ice packs.
i. Offer food and/or fluids to patient if appropriate.
j. Review all existing orders with physician to ensure that unnecessary or uncomfortable procedures or treatments are discontinued including:
   i. Routine labs and x-rays
   ii. Routine medications not related to comfort
   iii. Blood glucose monitoring, pulse oximetry, hydration IVs, antibiotics, and blood products

3. Licensed healthcare provider or designee shall provide information to the family about what to expect during the dying process and the care the patient is receiving.
4. The healthcare team shall ensure the family/next of kin is provided reasonably brief period of accommodation prior to discontinuing cardiopulmonary support.
5. Recognize and support patient/family/significant other's grieving behaviors.
   a. Provide support and reassurance that the goal of care is patient comfort.
   b. Consider referral to hospice.
   c. Refer to social worker for patient/family support.
   d. Refer to Chaplain as appropriate.
   e. Provide support and reassurance and allow time for all involved to express emotions and share concerns. Be sensitive to emotional reactions of patient/family.
   f. Provide privacy for families as needed.
   g. Obtain contact information of family members and place in chart in event they need to be contacted when patient deteriorates or dies.
   h. Consider ordering "Comfort Care Cart" from Dietary.
6. Be sensitive and open to cultural diversities related to the grieving process. Support a healing atmosphere.
7. If a family member is alone, offer to contact other family members and/or outside support.
8. When a family is preparing to leave, provide them with information regarding funeral arrangements and support services.
9. Prepare patient and room after death. If appropriate:
   a. Place signage on door directing visitors to see nurse before entering
   b. Place pillow under patient's head
   c. Place patient in position of comfort with fresh linen over them
   d. Dim lights
   e. Ask the patient/family about keeping door closed for privacy
10. A Physician, Administrative Supervisor, or designated Registered Nurse will pronounce the patient's death and document in the electronic health record.

D. RELATED DOCUMENT(S):

1. **Administrative Policy: Patient Access to Protected Health Information in the Designated Record Set – 516**

E. REFERENCES:

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

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: MONITOR TECHNICIANS (MTs): COMMUNICATION PROCESS

REVISION DATE(S): NEW

Department Approval:	**01/17**
Clinical Policies and Procedures Approval:	**02/17**
Nurse Executive Committee Approval:	**02/17**
Division of Cardiology Approval:	**04/17**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/17**
Professional Affairs Committee Approval:	**11/17**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the process
   a. Registered Nurses (RN) and nursing support staff will use to communicate with the Monitor Technicians (MT) at the central monitoring (CM) station.
   b. MTs will use to communicate with RN and nursing support staff.
   c. For ensuring visible electrocardiogram (ECG) tracings are displayed on centralized and decentralized monitoring stations.

B. **DEFINITION(S):**

1. Cardiac Monitored Units – Telemetry South Tower (2 East, 2 West, 4 East, 4 West) Telemetry 3 Pavilion (3P) and the Progressive Care Unit (PCU).
2. Central Monitoring (CM) station – A centralized location for monitoring the following patient information: ECG tracings, vital signs (VSS) such as respiratory rate, blood pressure, oxygen saturation, invasive line numerical values
3. Delay in Communication – Failure of MTs to notify a licensed RN immediately for interruptions in the display of a cardiac rhythm at the CM station. Failure of RNs and nursing support staff to communicate interruptions in monitoring to a MT at the CM station.
4. Emergency Department (ED) Cardiac Monitoring Stations – Stations A, B, C, and D
5. Interruptions in Monitoring – An event resulting in patient information not being displayed or not identifiable on centralized and decentralized monitors.
6. Medical Monitored Units – 4 Pavilion (4P) and PCU- may have patients requiring medical monitoring
   a. Medical Monitored is synonymous to heart rate monitoring
7. Decentralized Monitors – Monitor screens located on or near nurses' station in the Telemetry units, PCU, and 4P used to display duplicate patient information from the CM station. Decentralized monitors are also located in the ED.
8. Nursing Support Staff - Unlicensed staff e.g., Advanced Care Technicians (ACTs), Lift Team Technicians (LTT), Unit Secretaries (US)/Coordinators, Emergency Medical Technicians (EMT) and Transporters
9. Transmitter/transceiver (TTX) Devices – Automatic communication devices that allow bidirectional transmission of patient information from decentralized monitoring devices to the CM station
   a. The TTX devices used on Telemetry units, PCU and 4P are identified as one of the following: The TTX devices will be identified in this policy as a tele box:
      i. tele box

ii. telemetry box
iii. monitor

c. TTX devices are called monitors in the ED

10. Transmitter/transceiver (TTX) Number – A number assigned to each tele box. This number will be clearly displayed on each tele box at all times.
    a. Telemetry South Tower and 3P tele boxes are also labeled using labeling tape colors as follows:
        i. Blue = Private Rooms
        ii. Yellow = Semi-private A bed
        iii. Red = Semi-private B bed

C. **POLICY:**

1. ECG Alarm Default Parameters
    a. Alarm default parameters are identified by the Clinical Alarm Committee.
    b. The RN assigned to the patient will provide the MT instructions for modifying default alarm parameters based on patient assessment, history, medications, and treatments when necessary
    c. ED, Telemetry, and PCU RNs are responsible for:
        i. Validating alarm parameters per hospital policy
        ii. Modifying alarm default parameters from decentralized locations
        iii. Providing specific instructions to MTs to modify alarm default parameter s from the CM station
    d. MTs will not modify alarm default parameters independently. MTs may modify alarm default parameters when directed by a RN.
    e. MTs will contact the Telemetry ANM for instructions for modifying alarm default parameters for 4P patients. After making the alarm default parameter modifications as directed by the Telemetry ANM/Relief Charge RN, the MT will contact the 4P RN assigned to the patient.
    f. US/Unit Coordinators ACTs, LTTs, and other nursing support staff will not adjust alarm default parameters or make modifications to the decentralized monitors.
2. Alarm Notification Parameters
    a. MTs will notify the primary RN or designee when any of the following are displayed on the CM: The following list is not inclusive.
        i. Changes in patient's baseline cardiac rhythm or rate
        ii. Heart rate less than 50 or greater than 130 beats per minute (beats per minute (bpm)
        iii. Systolic blood pressure less than 90 millimeters of mercy (mmHG) or greater than 180 mmHG
        iv. Respiratory rate less than 10 breaths per minute or greater than 28 breaths per minute
        v. Oxygen saturation less than 92%
        vi. Interruptions in the following established values (previous viewable) if applicable:
            1) Oxygen saturation
            2) Respiratory rate
        vii. Changes in baseline cardiac rhythm or rate
            1) This includes changes in the R-to-R interval that are 2 seconds or longer, when the average heart rate is equal to or greater than 50
        viii. Ectopic findings as follows: (this is not an inclusive list)
            1) Ventricular Tachycardia – 3 or more Premature Ventricular Contractions (PVC) and/or new onset PVCs
            2) Ventricular Fibrillation (VF)
        ix. Asystole
        x. New ectopic beats, new events, or increase in frequency of the following:
            1) Premature Atrial Contractions (PAC)

2) PVCs
3) Changes in the PR interval prolonged greater than 0.21 seconds or less than or equal to 0.10 seconds
4) New junctional and idioventricular
5) New heart blocks
6) Widen QRS (new onset delayed conduction displayed as a QRS greater than 0.11 as directed by a RN)
7) Presence of cardiac device implemented beats e.g., pacemaker or implanted cardioverter defibrillator (ICD) not previously discussed by RN
8) Pacemaker failure to sense or failure to capture
9) Fusion beats (new onset or an increase in occurrences)

3. Emergency Department
   a. RN Responsibilities – ED RNs may delegate the following task to an Emergency Medical Technician (EMT)
      i. Admissions
         1) Admit patient to the monitor per department practices
         2) Enter patient's medical record number (MRN) in the MRN and Patient Name field
         3) Select the monitoring options required for the patient e.g., cardiac rhythm, blood pressure, oxygen saturation, respiration, etcetera as instructed by the RN
         4) Turn off monitoring options that are not required to decrease false alarms at the CM station
         5) EMTs may modify default alarm parameters as directed by an RN
      ii. Discharges
         1) Discharge patients according to department practices. This task may be delegated to an EMT
         2) Communicate discharges to the MT at the CM station by implementing the following:
            a) Select the *DISCHARGE* function
            b) Ensures all alarms are suspended by selecting the *SUSPEND MONITORING* function
      iii. Interruptions in Monitoring
         1) The RN or designee shall communicate interruptions in monitoring for procedures or tests outside of the ED to the CM station by selecting the *MENU SLEEP* function
   b. MT Responsibilities for Monitoring ED Patients:
      i. Verify patient's MRN is displayed on the monitoring screen
         1) If the MRN is not displayed contact the primary RN or designee
            a) When unable to contact the primary RN, contact the ED charge RN
      ii. Notify ED personnel as follows for:
         1) Alarm notifications as outlined in this policy
         2) Patient information not displaying at the CM
         3) Interruptions in monitoring
4. 4P and PCU: Nursing Staff Responsibilities
   a. Verifying a cardiac rhythm is present at the CM station
      i. 4P RNs, ACTs, US, and PCU ACTs will contact MTs by using the TCMC patient telephone located in the patient rooms or by using a telephone at the nurses' station
      ii. PCU RNs may contact MTs by using unit cellular telephones or ensure a cardiac rhythm is present by viewing the patient's rhythm on the decentralized monitor
   b. Admissions and Transfers (RN and ACT)
      i. Select a tele box

1) Call the MT and provide the following:
   a) Patient's first and last name (no initials)
      i) Initials may be used for PCU patients
   b) Medical Record Number (MRN)
   c) Room assignment
   d) Tele box number
      i) When the tele box is placed in the room by another staff, verify the tele box number

ii. Verify the patient's first and last name and MRN is displayed on the decentralized monitoring screen

iii. Once the patient arrives to the nursing unit and is attached to the tele box, verify a visible cardiac rhythm is displayed at the CM station as outlined in this policy.

c. Interruptions in Monitoring (RNs, ACTs, and LTT)

i. Interruptions in monitoring related to patient care or a patient leaving the unit for test or procedures shall be communicated to the MT as follows:

1) 4P RNs, ACTs, and LTTs call the MT from the patient's room or use a telephone located on the nursing unit prior to or after removing the tele box. Provide the rationale for interrupting monitoring.

2) PCU
   a) RNs may suspend the alarms by selecting the *Off Unit* function and the appropriate test or procedure label within the monitoring system to communicate the interruption in monitoring to the CM station.
   b) ACTs call the MT from the nurses' station

ii. Resuming Interruptions in Monitoring

1) Interruptions in monitoring shall be resumed immediately by RNs and ACTs after receiving notification
   a) RNs and ACTs shall resume monitoring as follows:
      i) Ensure the tele box is attached to the electrodes placed on the patient's chest
      ii) Verify a cardiac rhythm is visible at CM station as outlined in this policy

d. Discharges, Transfers Off Unit or Discontinuing Medical or Telemetry Monitoring

i. 4P RNs or designee will notify the MT at the CM station and request the MT discharge the patient from the CM

ii. PCU RNs may discharge patients as outlined for the Telemetry units

5. Telemetry South Tower and 3P: Nursing Staff Responsibilities

a. Verifying a cardiac rhythm is present at the CM station

i. RNs and ACTs will contact MTs by using the TCMC patient telephone located in the patient rooms or by using a telephone at the nurses' station

ii. RNs may ensure a cardiac rhythm is visible by viewing the patient's rhythm on the decentralized monitor

b. Admissions and Transfers – Assistant Nurse Manager (ANM)/Relief Charge/Designee

i. Prior to a patient's arrival to a Telemetry unit:

1) Notify the receiving unit nursing staff and provide the following information
   a) Patient's first and last name
   b) Room assignment
   c) Admitting or transfer diagnosis
   d) Admitting or transferring physician
   e) Name of transferring or admitting location

2) Notify the MT and provide the following information, prior to the patient's arrival to the nursing unit:
   a) Patient's name
   b) Room assignment

c) Admitting or transferring location

c. RN Responsibilities
  i. Admission and Transfers
    1) Verify the patient's first and last name, MRN, and room number is displayed on the decentralized monitor. See the Management of Telemetry Patients policy for additional information
    2) The following task may be delegated to an ACT
      a) Select the tele box for the patient room number and bed number assigned to the patient's room number and bed number if applicable
        i) When the tele box is placed in the room by another staff, verify the room number located on the tele box prior to applying to the patient
      b) Verify a visible cardiac rhythm is displayed at the CM station as outlined in this policy
  ii. Interruptions in Monitoring
    1) ACTs and LTTs
      a) Call the MT from the patient's room or use a telephone located on the nursing unit prior to or after removing the tele box. Provide the rationale for interrupting monitoring
      b) RNs may suspend the alarms by selecting the Off Unit function and the appropriate test or procedure label using the decentralized monitor to communicate the interruption in monitoring to the CM station.
  iii. Resuming Interruptions in Monitoring
    1) Interruptions in monitoring shall be resumed as outlined in the Management of Telemetry Patients policy.
    2) Verify a cardiac rhythm is visible as outlined in this policy
  iv. Discharges
    1) RNs may communicate discharges to the CM station by implementing one of the following:
      a) Discharge the patient using the decentralized monitor
      b) Notify the MT to discharge the patient from the CM station
        i) This task may be delegated to an ACT, LTT, or US

6. MT Responsibilities: Telemetry Units, PCU, and 4P
  a. Admissions and Transfers
    i. Enter patient information in the CM
      1) Use the bed board system to verify the spelling of the patient's name and the MRN
    ii. Enter the following information:
      1) Patient's name (first and last) no initials
        a) Exceptions: patient's initials may be used for PCU patients
      2) Medical record number
      3) Room Number
    iii. Review alarm default parameters per hospital policy.
      1) If alarm default parameters have been modified, contact the primary RN for instructions to adjust the parameters to default settings or to continue current default parameters
    iv. Implement the MT Shift Task Process outlined in the Management of Telemetry Patient policy
    v. Monitor the patient's admission and transfer status using the bed board system
      1) Contact the nursing units to verify patient's arrival 30 minutes after a bed is placed in the *Ready* status, if a cardiac rhythm is not displayed at the CM station

a) Call the nursing units every 30 minutes until a cardiac rhythm is displayed or until notification has been obtained from nursing staff indicating one of the following:
   i) Patient has not arrived to the unit
   ii) Change in bed or unit assignment
   iii) Cancelation of the admission or transfer
   iv) RN or ACT providing direct care that delays applying the tele box

b. Discharges
   i. Discharge the patient from the CM as directed by the primary RN
   ii. Update the Shift Hand-off Worksheet as outlined in the Management of Telemetry Patients policy

c. Interruptions in Monitoring
   i. When notified by nursing staff or transporters a patient is leaving a unit for a test or procedure or for notification of patient care
      1) Suspend the alarms, select the appropriate label if informed of the location of the test or procedure
   ii. Interruptions without notifications from nursing staff
      1) Notify a RN or ACT immediately when a patient's cardiac rhythm is not visible
      2) Call the Telemetry AMN/Relief Charge if one or both of the following occur:
         a) Unable to contact nursing staff
         b) Monitoring is not resumed after notifying nursing staff and the nursing staff did not inform the MT of the rationale for the delay in monitoring or acknowledge they are aware of the interruption
   iii. Delay in resuming monitoring after receiving notification from a Transporter
      1) When a Transporter is unable to reapply a tele box or after reapplying a tele box a cardiac rhythm is not displayed on the CM, MTs will:
         a) Call the nurses' station and inform a RN or ACT
         b) If monitoring is not resumed after informing a RN or ACT implement the process outlined in Alarm Notification: Nursing Staff

d. Alarm Notification: Nursing Staff
   i. 4P and PCU
      1) Contact the primary/relief RN assigned to the patient to communicate the alarm notification.
      2) Document the primary/relief RN's name and time on the MT's Shift Hand-off tool.
      3) When the primary/relief RN is not available:
         a) Communicate the alarm notification to the staff answering the telephone
         b) Document the staff's name and time on the MT's Shift Hand-off tool
         c) Inform the staff to tell the primary or relief RN contact the MT immediately to discuss the alarm notification
      4) When the primary/ relief RN does not contact the MT to discuss the alarm notification, the MT will call the unit a 2nd time and request to speak with the primary RN.
      5) When the primary RN remains unavailable, the MT will:
         a) Contact the Telemetry ANM/Relief Charge to obtain further monitoring instructions
         b) The Telemetry ANM/Relief Charge will contact the 4P or PCU ANM/Relief Charge to communicate the alarm notification
         c) The 4P or PCU ANM/ Relief Charge will contact the primary/relief

RN to ensure appropriate assessment and monitoring plans are discussed and implemented.

6) When the Telemetry ANM/Relief Charge is not available, the MT will contact the Rapid Response RN by telephone for further monitoring instructions

ii. Telemetry Units
1) Notify the nursing staff
2) When unable to contact the primary/relief RN, the MT will contact:
a) Any RN or ACT on the patients assigned unit
b) When unable to contact any RN or ACT, notify the PRN RN
c) When unable to contact the PRN RN, notify the ANM/relief charge
i) When unable to contact the ANM/relief charge notify the Rapid Response RN by telephone

7. LTT and US Responsibilities
a. Communicate messages from RNs and ACTs to the MT at the CM station
b. Communicate messages from the MTs to the RNs and ACTs

8. Transporting Staff Responsibilities
a. Prior to transporting a patient from a nursing unit:
i. Notify the primary/ relief RN
ii. Notify the MT at the CM station and provide the following:
1) Patient's name
2) Room Number
3) Department name of test or procedure
iii. Remove tele box and leadwires from the electrodes
1) Prior to removing the tele box and leadwires, inform the patient and receive their verbal consent
a) When a patient refuses to have the tele box and leadwires removed ask a RN or ACT to remove the tele box and leadwires
b) Remove the electrodes per the test or procedure department's policy
iv. Place the tele box and leadwires on the patient's bedside table
v. Do not place the tele box and leadwires on the bed, chair, or meal tray
vi. Transport the patient off the unit per department process
b. Returning Patients to a Nursing Unit
i. Notify the primary/relief RN or ACT
ii. If the electrodes are attached to the patient's chest, reapply the leadwires and tele box. If the leadwires have been removed, inform the MT and ask an ACT or RN to reapply the leadwires
iii. Call the MT from the patient's room provide the following information
1) Patient's Name
2) Room Number
3) Ask the MT if a rhythm is displayed at the CM station if the answer is:
a) Yes, a cardiac rhythm is visible at CM station
i) Place the upper side rails in the up position, place the bed in the low position and lock the wheels
ii) Place the call button and TV remote within the patient's reach
iii) Ensure the bedside table is within the patient's reach
b) No, a cardiac rhythm is not visible CM station
i) Place the upper side rails in the up position, place the bed in the low position and lock the wheels
ii) Place the call button and TV remote within the patient's reach and ensure the bedside table is within the patient's reach

iii) Leave the patient's room and inform any RN or ACT, the patient's cardiac rhythm is not displayed for the MT

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

1. Patient Care Services Policy: Clinical Alarm Management
2. **Patient Care Services Policy: Management of ECG Strips**
3. Patient Care Services Policy: Rapid Response Team and Condition Help (H)
4. Telemetry Policy: Management of Telemetry Patients

E. **REFERENCE(S):**

1. General Electric (GE) Company. (2014). Carescape central station v1: Participant notebook.
2. Nihon Kohden. (2015). Clinical reference guide: CNS-6201 2nd generation central monitor bedside monitoring and telemetry applications. Version 02-53
3. Northwestern Memorial Hospital. (2008). Telemetry: Care of the patient on centralized telemetry monitoring. Patient Care Service Policy. Retrieved from http://ww2.nmh.org/oweb/MagnetDoc/02_tl_transformational_leadership/tl5-e__-_telemetry_down_time_procedure_policy___5.11.pdf
4. Tri-City Medical Center. (2015). Clinical alarm management
5. Tri-City Medical Center. (2016). Management of telemetry patients
6. Welch Allyn. (2014). Telemetry monitoring medical/surgical floor. Retrieved from www.welchallyn.com
7. Lazzara, P.B., Santos, A.R., & Walker, R. (2010, November). The evolution of a centralized telemetry program. *Nursing Management*. DOI-10.1097/01.NUMA.0000388670.02663.b6
8. Whelan, L. and Stanton, M.P. (2013, March). Risk management updating telemetry practices to improve the culture of safety. *Nursing Management*. DOI-10.1097/01.NUMA.0000427192.74586.45
9. Whalen, D. A., et al. (2014, September/October). Novel approach to cardiac alarm management on telemetry units. *Journal of Cardiovascular Nursing*. DOI: 10.1097/JCN.0000000000000114

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**NEWBORN SCREENING, COLLECTION OF SPECIMEN**
Purpose:	All newborn babies are required to have a newborn screening test before the baby is discharged. Proper collection is mandatory. This procedure specifically addresses the proper collection of these blood specimens for the California Newborn Screening Program to detect such inborn errors as phenylketonuria (PKU), galactosemia, hypothyroidism, and other metabolic/genetic disorders. ~~State regulations require that the sample be collected at discharge, prior to a red blood cell transfusion, or for infants with extended hospital stays, on the sixth day of life. To decrease the chances of a false positive (requiring additional testing) or false negative (resulting in a missed case), the State strongly recommends delaying collection on healthy full term infants until~~ **at least 2412 hours of ~~age.~~**
Supportive Data:	**Required under California Department of Health Newborn Screening - Title 17.** ~~Authorized to Perform Procedure: RN, LVN, Phlebotomist, and Clinical Laboratory Scientist.~~ ~~Blood collection and testing are under the supervision of the Laboratory Point of Care Coordinator and under the jurisdiction of the Laboratory Medical Director.~~
Equipment:	1. Newborn Screening Form 2. ~~70% isopropyl alcohol~~ **Skin cleanser per unit standards** 3. Sterile Lancet type device 4. Dry ~~Sterile~~ gauze 5. Heel Warmer 6. Single dose, pre-filled twist-tip vial Sucrose 24% **(RN to administer, if ordered) (note: this is outside the scope of practice for phlebotomist)**

A. **PROCEDURE:**

1. Initial newborn screening specimens shall be collected on State provided filter forms~~.~~ ~~(See attachment 1 for instructions on form completion).~~
   - **a.** **Clinical**~~Nursing~~ staff shall accurately complete the demographic data. The follow-up provider (physician) and provider number must be completely accurate. ~~Neonatal Intensive Care Unit (NICU) babies will have the medical director of NICU listed as the follow-up provider. NOTE:~~
     - **i.** A ballpoint pen should be used to print clearly.
     - ~~a.~~**ii.** If the form is not completed **in its entirety** ~~including the ethnic background~~, the lab must contact the nurse to complete the form.
   - b. The nurse or phlebotomist must fill in the date~~,~~ **and time** of collection, **and** initial~~s~~ **as the collector.**~~, and the first 3 letters of the last and first name.~~
2. Follow proper patient identification and labeling procedure:
   - a. Verify the infant's name and medical record number on the armband against all the demographics on the Newborn Screening Form.
     - ~~i. If infant is receiving TPN at the time of collection, mark "YES" on the Newborn Screening Form, otherwise mark "NO."~~
     - ~~For the "all feeding" section, provide all nutritional intakes since birth.~~
   - **b. Place additional infant label on back of Newborn (NB) Screen Blood Collection card to ensure specimen test card is still identified with NB should the top page with infant label become separated. Attach label to back side of lower portion. Lab will not process if it is separated.**
   - ~~b.~~**c. Verify all information on the Newborn Screening Form is correct with a second RN.**

Department Review	Clinical Policies & Procedures	Nursing Executive Council	~~Division of Neonatology~~ Perinatal Collaborative Practice	Department of Pediatrics	Department of Pathology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
03/00, 05/12, **02/15, 11/16**	05/12, **02/15, 11/16, 03/17**	05/12, **02/15, 05/17**	**08/16, 07/17**	**08/17**	**03/16, 09/17**	09/12, **10/17**	10/12, **11/17**	11/12

3. Timing of Collection:
   a. **In postpartum collect the specimen between~~at~~ 24-48 hours of age.**
   b. **In NICU c**~~C~~ollect the specimen **at 48 hours of age** ~~**or** as close to time of discharge as **possible** is practical when discharge occurs before six days of age~~.
      ~~i. The newborn should be at least 12 hours old since a neonate's metabolic system is still stabilizing before 12 hours of age.~~
   c. If for any reason (e.g., transfusion, discharge earlier than 12 hours or hospital error) the specimen is collected prior to 12 hours, a second specimen will be required.
   ~~b.~~**d.** **In Critically ill newborns, ~~T~~the attending NICU P~~p~~hysician/Allied Health Professional (AHP) ~~attending critically ill newborns who require special care~~ may postpone the collection of newborn screening specimen until the newborn's emergency condition is stabilized.**
4. Dried Blood Spot (DBS) Collection: Instructions for collecting adequate dried blood spots are on the back of the California Newborn Screening Specimen Collection Card. ~~(See attachment)~~
   a. ~~Avoid Touching the Specimen Collecting Area at any time with gloved or ungloved hands. Oil, lotion, or powder from hands or gloves can prevent the blood from spreading evenly and thoroughly. Use unpowdered gloves.~~**Do not handle the blood collection area of specimen collection card prior to, during, or following sampling.**
   b. A new test request form must be used for each collection. If a mishap occurs during a collection, use a new specimen collection card. ~~(Refer to attachment 2, Steps to Collecting the Newborn Screening Blood Test.)~~
   c. Do not use capillary tubes for collecting the blood to **apply to** ~~spot on~~ the card. It can damage the filter paper, resulting in an inadequate specimen.
   ~~c.~~**d.** **See Patient Care Services Procedure: Collection of Blood Specimen by Skin Puncture for specimen collection.**
   ~~d. Warm the infant's heel (optional) : This can increases blood flow through the site. Use a heel warmer) according to manufacturer's instructions.~~
   ~~e. Administer 2 gtts (drops) 24% sucrose solution on the tip of the baby's tongue at 2 - 5 minutes prior to puncture of newborn heel.~~
      ~~i. Provides calming effect during painful procedure~~
      ~~ii. May repeat as needed during the procedure~~
      ~~iii. Refer to WCS Policy Pain Management for Newborn/NICU~~
      ~~**e per unit standards.**~~
   ~~f. **Let the site air-dry.**Site of Puncture: Puncture site is indicated on diagram by shaded areas on heel. The blood must be obtained from the infant's heel using the most medial or lateral portion of the plantar surface of the heel, where "medial" is defined as closest to the midline of the body, "lateral" is defined as away from the midline of the body, and "plantar surface" as the walking surface of the foot.~~

   ~~NOTE: Previous puncture sites or the curvature of the heel must **not** be used.~~
   ~~**Perform the puncture: To obtain sufficient flow of blood, the infant's heal should be punctured with a sterile lancet device appropriate to gestational age.**~~
   ~~g. Application Of Capillary Blood To Filter Paper:~~
      ~~i. Allow a large drop of blood to accumulate; wipe away with a sterile gauze. Allow a second large drop of blood to accumulate, then apply the drop to one side of a circle on the DBS collection card. Repeat for each circle. Apply gentle pressure to heel & ease intermittently so blood flows freely. NOTE: Milking or squeezing the puncture may cause hemolysis of the specimen and admixture of tissue fluids with the specimen.~~
   e. Follow instructions on Newborn Screening Collection card.
      ~~ii. Allow circles to fill by natural flow until the circle is **completely** filled when applying a large accumulated drop of blood (one per circle) to the specimen collection card. Avoid repeated applications of blood to the specimen collection card to fill any one circle. NOTE: Layering or application of successive drops of blood in the same circle causes caking and/or non-uniform concentrations of blood.~~

~~iii.~~**i.** ~~Examine both sides of the collection card to assure that the blood has penetrated & saturated the paper. The circles should be filled **completely** when viewed from both sides.~~ Fill all ~~five~~ circles.

~~iv. Avoid repeated applications of specimen collection card to the heel to fill any one circle.~~

~~5. Puncture Site Care~~

~~i. Hold a sterile gauze pad pressed against the puncture site until the bleeding stops.~~

~~Dress the wound site with gauze.~~

~~6.~~**5.** Use of Venous or Arterial Blood:

a. A heel stick is strongly preferred.

b. If unable to obtain a heel stick specimen due to prematurity or other issues with infant, arterial or venous blood may be used after the line has been properly cleared.

c. Allow blood to freely drop from the syringe onto the filter paper, filling each circle completely.

d. Mark "Other" in type of specimen category on test request form, and indicate source of blood (**Umbilical Arterial Catheter**~~uac~~, etc.)

~~7.~~**6.** Infants Requiring Transfusions. If a transfusion is anticipated:

a. Collect the specimen prior to the transfusion of red blood cells (RBC), even if the newborn is under 12 hours of age. Infants who are transfused with red blood cells must have a specimen collected prior to the transfusion. (Transfusions with plasma, platelets, or albumin will not significantly affect the screening.)

~~b.~~ If the neonate is less than 12 hours old at the time the pre-transfusion specimen is collected **or if no adequate specimen was obtained prior to transfusion**~~.~~, ~~a seconda~~ specimen should be collected ~~between~~ 24 – **48** hours after the last transfusion ~~and six days of age~~.

~~c.~~**b.** ~~If no adequate specimen was obtained prior to transfusion, collect one sometime between 24~~ **24- 48** ~~hours post-transfusion and the sixth day of life.~~

~~8.~~**7.** Processing Newborn Screening Forms:

a. Allow the blood to thoroughly dry at room temperature for at least 3 hours and follow hospital policy for processing the specimen. Keep away from heat lamps, direct sunlight, and humidity.

b. Note: Touching or smearing the blood spots should be avoided. Blood spots on the filter paper should not be heated, stacked or allowed to touch other surfaces during the drying process.

c. The ~~nurse~~**health care provider** will order the ~~PKU (~~Newborn **Metabolic** Screening ~~)~~**(NBMS)** test in **the Electronic health record (EHR)** ~~Compass. PKU (Newborn Screening) must be ordered separately from other lab tests such as total bilirubin or neonatal panel.~~

d. **Do not seal the bag containing the specimen.** ~~o not seal the bag containing the specimen.~~

~~e. Distribution of copies of the Newborn Screening Specimen Collection Card:~~

~~i. White: Newborn Screen copy goes to the state of California~~

~~ii. Yellow: Sender's copy, remains in the patient's medical record~~

~~iii. Pink **and blue**: Parent's copy~~

~~f.~~**e.** The newborn screening requisition form will be taken to the Laboratory and the clerical staff will receive them and place the Accession Number on the slip. Note: The lab staff will call nursing for information if the forms are not completely filled out.

f. The clerical staff will log these specimens on the Newborn Screening Form log. Specimens that are awaiting transport shall be stored at room temperature, away from heat and moisture.

8. Document completion and RN verification/ witness of the newborn screen in the EHR.

B. LABORATORY:

1. **The clerical or phlebotomy staff will receive the specimen in the Laboratory Information System (LIS) and place the Accession Number on the slip.**
   a. **If dispatched receive using the miscellaneous reference lab as the location.**
   b. **If the patient was discharged and the NBMS discontinued or was not initially ordered, re-order the NBMS using Department Order Entry using Miscellaneous Reference Lab as the location.**
2. **Check the NBMS collection form for completeness and that the collection time is greater than 12 hours of age.**
   a. **Lab staff will call nursing for information if the forms are not completely filled out.**
3. **The clerical staff will log these specimens on the Newborn Screening Form Log and place them in the appropriate bin in the Chemistry refrigerator #5 at 2-8 degrees C for courier pickup.**
4. **Completion in Cerner:**
   a. **Using Batch Result Entry enter Newborn Metabolic Screening.**
   b. **A list of NBMSs will display. The default entry is "See Separate Report"..**
      i. **Be sure all accession numbers have a check mark displayed.**
   ~~9.~~**c. Click Verify.**

~~B.~~**C. PROCEDURE IN EVENT SPECIMEN IS NOT COLLECTED PRIOR TO DISCHARGE:**

1. Notify the appropriate Unit Clinical Manager that the specimen was not collected. Arrangements for follow-up of infant will be made by the appropriate Unit Clinical Manager.
2. If no specimen is obtained for Newborn Screening, **fill in "Specimen Not Obtained" section on the Newborn ~~m~~Metabolic Screening form.** ~~it is mandatory that the state be notified by completing **the regular Newborn screening Test Request Form (TRF).** a "Hospital Report of Newborn Screening Specimen Not Obtained" (NBS-NO). Follow instructions on the NBS-NO form for appropriate completion and distribution.~~ Situations which might apply include:
   a. A newborn that is transferred to another facility.
      i. The receiving hospital is responsible for obtaining the specimen.
   b. A newborn that expires prior to **48 hours** ~~6 days~~ of age.
   ~~c. Parents who refuse to have testing done.~~
   ~~d.~~**c.** Staff error results in infant being discharged without specimen being collected.
3. If newborn's parent(s) refuses testing, **the~~a~~** "Newborn Screening Test Refusal" (NBS-TR) form~~,~~ ~~also~~ **must** be completed and submitted.
4. ~~NBS-NO and~~ NBS-TR forms may be obtained from the OB Clinical Manager, OB Charge Nurse, OB Patient Data Coordinator, or the NICU Unit Secretary.

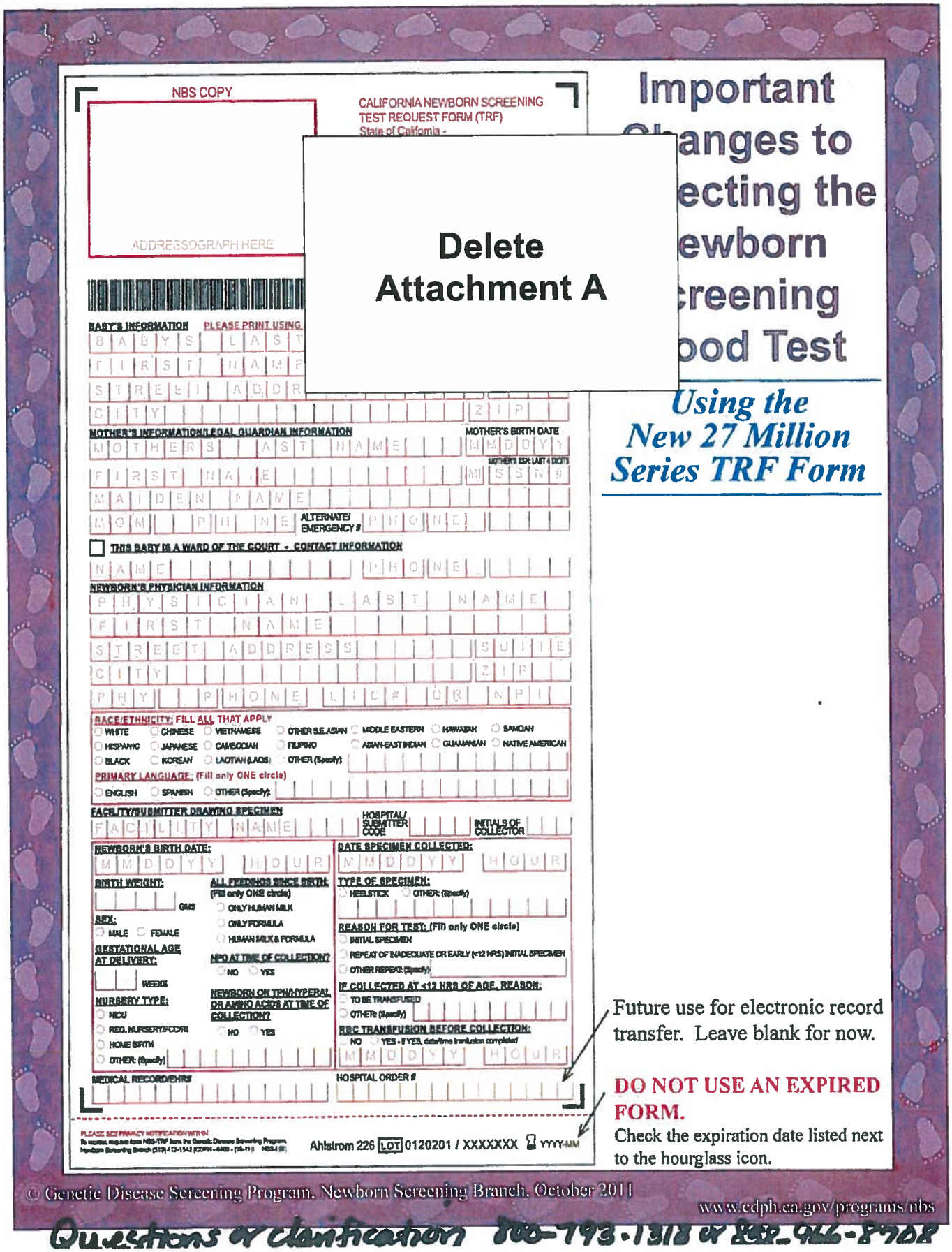
D. RELATED DOCUMENT(S):

1. ~~WCS~~ **NICU Pain Management, Neonates & Infants** ~~for Newborn/NICU~~**Policy**

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

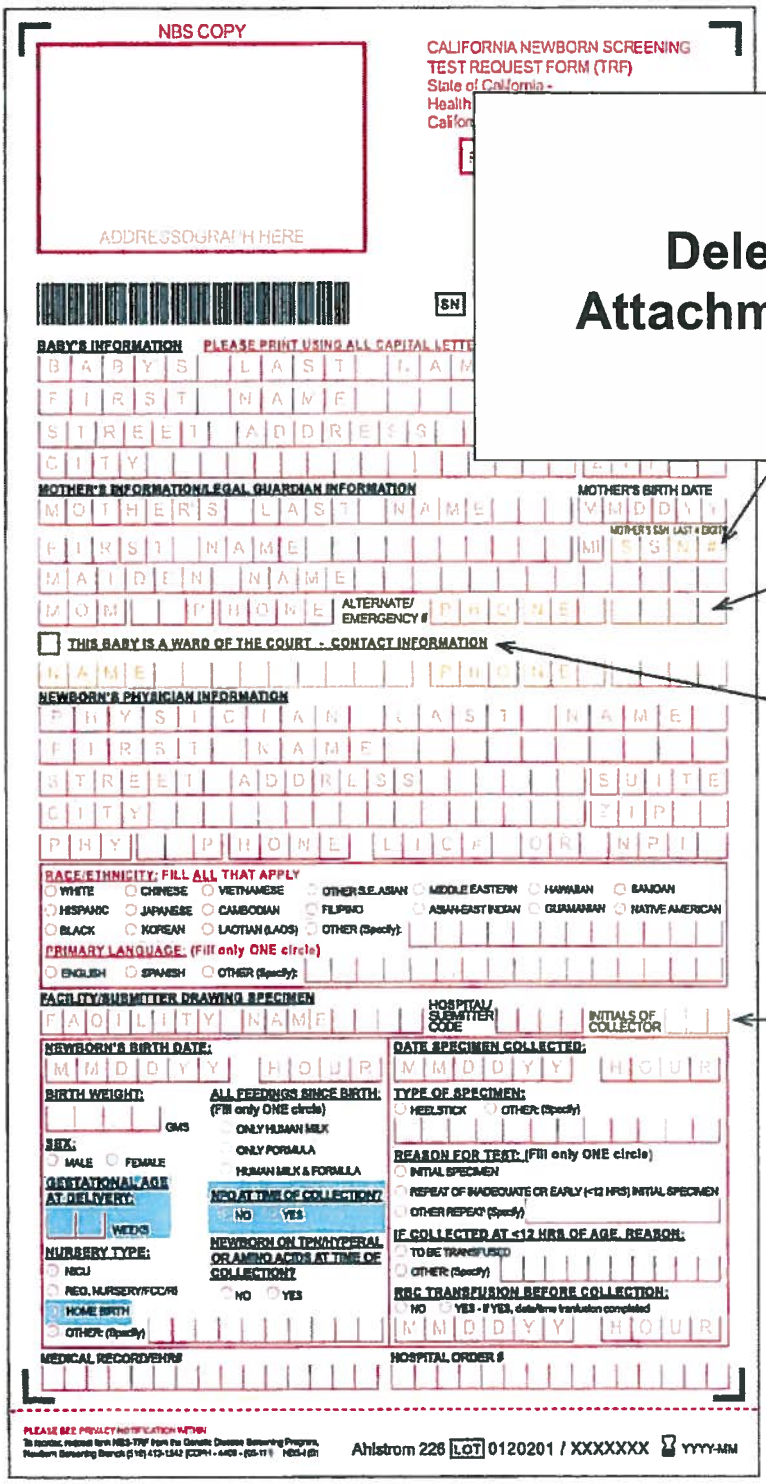
1. **"Blood Collection on Filter Paper for Neonatal Screening Programs" NCCLS Document LA4-A2 Vol. 12, No. 13, July 2002.**
2. AWHONN Evidence-based Clinical Practice Guideline. Neonatal Skin Care. 2008.
3. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses - Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC
~~3.~~**4.** State of California Website, www.dhs.ca.gov.pcfh/gdb/html/NBS/ProgramOVforProviders.htm
~~4.~~**5. The California Newborn Screening Program. (2013, April). New Addition to Newborn Screening: Severe Combined Immunodeficiency (SCID).** ***Newborn Screening News Issue #16, pp.1-4***

~~Attachment A~~



Questions or clarification 510-793-1318 or 800-942-8932

~~Attachment B~~



Delete Attachment B

Changes
d
ields

ast four digit or use 9999 if there is no number.

An additional number to contact parent, guardian or emergency contact.

If baby is a ward of the court, check box.

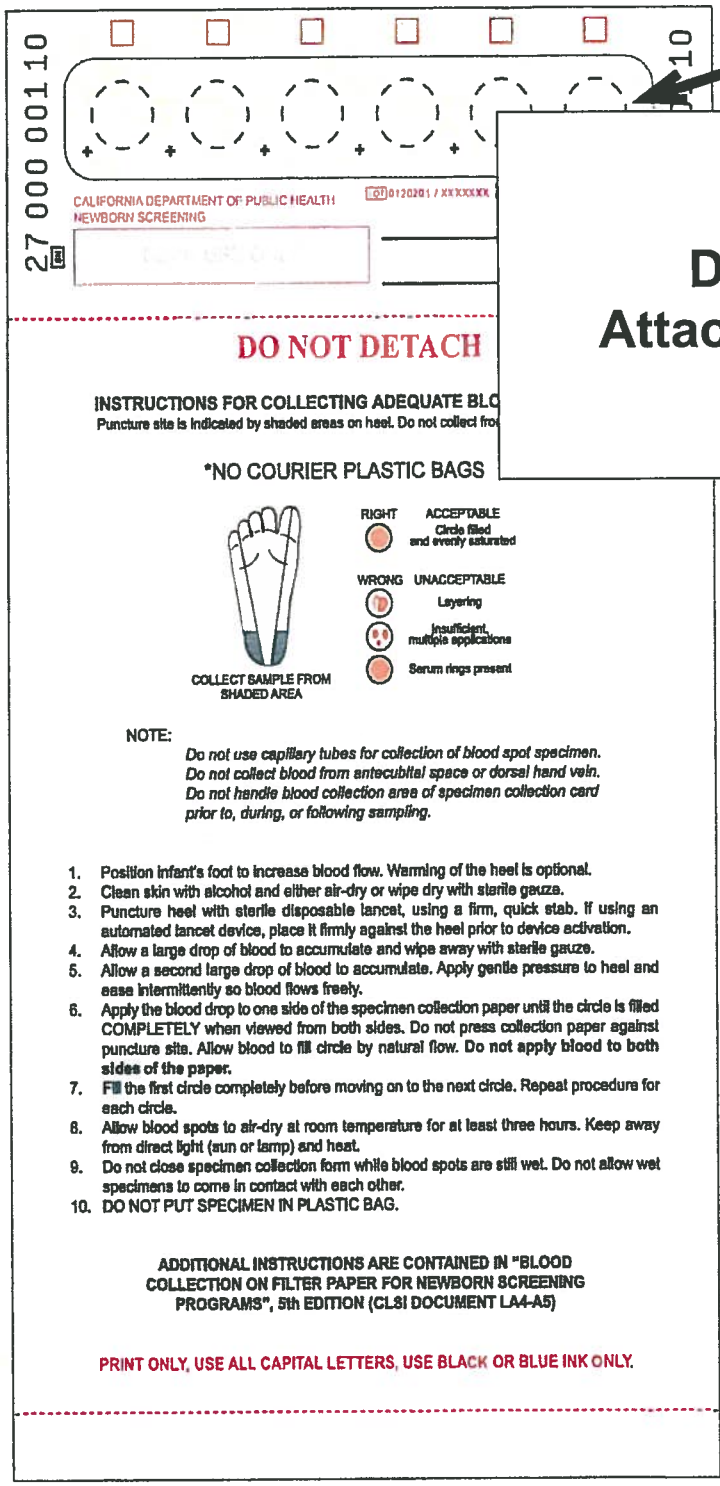
- If other legal guardian, social worker, or caretaker is available, enter in name and phone number.
- Enter mother's information as well.

This field has moved.

See page 4 for instructions.

- Gestational Age
- NPO at Time of Collection
- Home Birth

~~Attachment C~~


27 000 001 10

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING

DO NOT DETACH

INSTRUCTIONS FOR COLLECTING ADEQUATE BLO
Puncture site is indicated by shaded areas on heel. Do not collect fro

*NO COURIER PLASTIC BAGS

COLLECT SAMPLE FROM SHADED AREA

RIGHT ACCEPTABLE
Circle filled and evenly saturated

WRONG UNACCEPTABLE
Layering
Insufficient, multiple applications
Serum rings present

NOTE:
Do not use capillary tubes for collection of blood spot specimen.
Do not collect blood from antecubital space or dorsal hand vein.
Do not handle blood collection area of specimen collection card prior to, during, or following sampling.

1. Position infant's foot to increase blood flow. Warming of the heel is optional.
2. Clean skin with alcohol and either air-dry or wipe dry with sterile gauze.
3. Puncture heel with sterile disposable lancet, using a firm, quick stab. If using an automated lancet device, place it firmly against the heel prior to device activation.
4. Allow a large drop of blood to accumulate and wipe away with sterile gauze.
5. Allow a second large drop of blood to accumulate. Apply gentle pressure to heel and ease intermittently so blood flows freely.
6. Apply the blood drop to one side of the specimen collection paper until the circle is filled COMPLETELY when viewed from both sides. Do not press collection paper against puncture site. Allow blood to fill circle by natural flow. Do not apply blood to both sides of the paper.
7. Fill the first circle completely before moving on to the next circle. Repeat procedure for each circle.
8. Allow blood spots to air-dry at room temperature for at least three hours. Keep away from direct light (sun or lamp) and heat.
9. Do not close specimen collection form while blood spots are still wet. Do not allow wet specimens to come in contact with each other.
10. DO NOT PUT SPECIMEN IN PLASTIC BAG.

ADDITIONAL INSTRUCTIONS ARE CONTAINED IN "BLOOD COLLECTION ON FILTER PAPER FOR NEWBORN SCREENING PROGRAMS", 5th EDITION (CLSI DOCUMENT LA4-A5)

PRINT ONLY, USE ALL CAPITAL LETTERS, USE BLACK OR BLUE INK ONLY.

New!

Delete Attachment C

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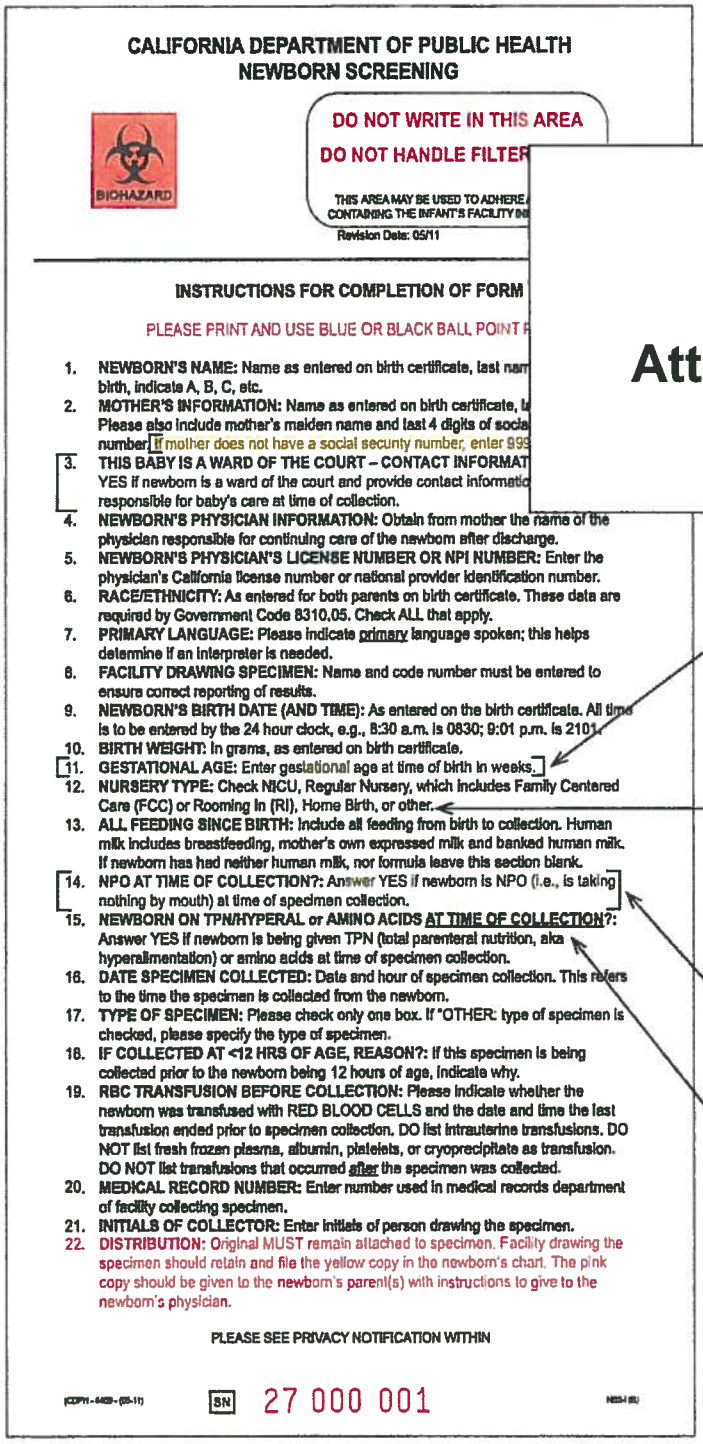
nen.

Six spots are needed for increased number of disorders added to the California screening panel.

~~Attachment D~~



CALIFORNIA DEPARTMENT OF PUBLIC HEALTH
NEWBORN SCREENING

BIOHAZARD

DO NOT WRITE IN THIS AREA
DO NOT HANDLE FILTER

THIS AREA MAY BE USED TO ADHERE
CONTAINING THE INFANT'S FACILITY

Revision Date: 05/11

INSTRUCTIONS FOR COMPLETION OF FORM

PLEASE PRINT AND USE BLUE OR BLACK BALL POINT

1. **NEWBORN'S NAME:** Name as entered on birth certificate, last nam
birth, indicate A, B, C, etc.
2. **MOTHER'S INFORMATION:** Name as entered on birth certificate,
Please also include mother's maiden name and last 4 digits of socia
number. If mother does not have a social security number, enter 99
3. **THIS BABY IS A WARD OF THE COURT – CONTACT INFORMAT**
YES if newborn is a ward of the court and provide contact informatic
responsible for baby's care at time of collection.
4. **NEWBORN'S PHYSICIAN INFORMATION:** Obtain from mother the name of the physician responsible for continuing care of the newborn after discharge.
5. **NEWBORN'S PHYSICIAN'S LICENSE NUMBER OR NPI NUMBER:** Enter the physician's California license number or national provider identification number.
6. **RACE/ETHNICITY:** As entered for both parents on birth certificate. These data are required by Government Code 8310.05. Check ALL that apply.
7. **PRIMARY LANGUAGE:** Please indicate primary language spoken; this helps determine if an interpreter is needed.
8. **FACILITY DRAWING SPECIMEN:** Name and code number must be entered to ensure correct reporting of results.
9. **NEWBORN'S BIRTH DATE (AND TIME):** As entered on the birth certificate. All time is to be entered by the 24 hour clock, e.g., 8:30 a.m. is 0830; 9:01 p.m. is 2101.
10. **BIRTH WEIGHT:** In grams, as entered on birth certificate.
11. **GESTATIONAL AGE:** Enter gestational age at time of birth in weeks.
12. **NURSERY TYPE:** Check NICU, Regular Nursery, which includes Family Centered Care (FCC) or Rooming In (RI), Home Birth, or other.
13. **ALL FEEDING SINCE BIRTH:** Include all feeding from birth to collection. Human milk includes breastfeeding, mother's own expressed milk and banked human milk. If newborn has had neither human milk, nor formula leave this section blank.
14. **NPO AT TIME OF COLLECTION?:** Answer YES if newborn is NPO (i.e., is taking nothing by mouth) at time of specimen collection.
15. **NEWBORN ON TPN/HYPERAL or AMINO ACIDS AT TIME OF COLLECTION?:** Answer YES if newborn is being given TPN (total parenteral nutrition, aka hyperalimentation) or amino acids at time of specimen collection.
16. **DATE SPECIMEN COLLECTED:** Date and hour of specimen collection. This refers to the time the specimen is collected from the newborn.
17. **TYPE OF SPECIMEN:** Please check only one box. If "OTHER: type of specimen is checked, please specify the type of specimen.
18. **IF COLLECTED AT <12 HRS OF AGE, REASON?:** If this specimen is being collected prior to the newborn being 12 hours of age, indicate why.
19. **RBC TRANSFUSION BEFORE COLLECTION:** Please indicate whether the newborn was transfused with RED BLOOD CELLS and the date and time the last transfusion ended prior to specimen collection. DO list intrauterine transfusions. DO NOT list fresh frozen plasma, albumin, platelets, or cryoprecipitate as transfusion. DO NOT list transfusions that occurred after the specimen was collected.
20. **MEDICAL RECORD NUMBER:** Enter number used in medical records department of facility collecting specimen.
21. **INITIALS OF COLLECTOR:** Enter initials of person drawing the specimen.
22. **DISTRIBUTION:** Original MUST remain attached to specimen. Facility drawing the specimen should retain and file the yellow copy in the newborn's chart. The pink copy should be given to the newborn's parent(s) with instructions to give to the newborn's physician.

PLEASE SEE PRIVACY NOTIFICATION WITHIN

SN 27 000 001

Delete Attachment D

Read carefully:
New instructions for

- Such as the medical social worker

New Instruction # 11
- Add gestational age on every screen

New Field
- Check if Home Birth
- For others please list: Pediatric Unit, Outpatient Lab, etc.

New Instruction # 14
- If NPO at collection, check Yes or No on All Infants.

15. Check Yes or No on ALL infants.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/06	**SUBJECT:** Pet Therapy
REVISION DATE: 07/06, 08/08, 07/11	**POLICY NUMBER:** II.C

Department Approval:	09/17
Clinical Policies & Procedures Committee Approval:	~~06/14~~09/17
Nursing Executive Council Approval:	~~07/14~~09/17
Infection Control Committee Approval:	~~01/15~~10/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/17
Professional Affairs Committee Approval:	~~02/15~~11/17
Board of Directors Approval:	02/15

A. **PURPOSE:**

1. Pet Therapy is utilized to make hospitalization a less threatening experience and promote therapeutic patient goals. It is used to augment healing and to provide incentives to patients who are debilitated and/or uncommunicative.

B. **POLICY:**

1. All patients of Tri-City ~~Medical Center~~Healthcare District (TCHD) are eligible for participation in the program~~, with permission of the physician~~ in order to promote cognitive skills, physical functioning and improve patient psycho-social well-being.

~~1.~~**2.** Patients of ~~Tri-City Medical Center~~**TCHD** may request specific visitation on Acute Rehabilitation, Inpatient/Out Patient Behavioral Health, Cardiac Wellness, 4 Pavil~~l~~ion, 2 Pavil~~l~~ion, 1 North, Telemetry, ~~Intensive Care~~ and Emergency Services.

a. Therapy dogs may not visit unauthorized areas or patients with the following:

i. Shared rooms, unless both patients ~~have doctor's approval and~~ agree.

ii. Patients with spleen removed or immuno compromised (neutropenic)

iii. If an immuno compromised patient would like a pet therapy visit this is determined at the discretion of the patient's physician.

~~i.~~**1) Infection Control must be consulted before permitting pet visits for patients in various immune deficiency states.**

iv. Patients in isolation (Airborne, Droplet and Contact) **including patients with:**

1) Tuberculosis (dogs and handlers can acquire tuberculosis).

2) Patients ~~who~~with positive test for methicillin-resistant Staphylococcus aures (MRSA)~~ positive~~; dogs and their handlers can acquire MRSA.

~~ii.~~**3) Patients colonized or infected with vancomycin-resistant enterococci (VRE), Salmonella, Campylobacter, Shigella, Strep A, Ringworm, Giardia, or Amebiasis.**

~~ii.~~**v.** Food prep**aration** area or carts.

~~iii.~~**vi.** Medication preparation or storage area or carts.

~~iv.~~**vii.** High risk areas; Intensive Care Unit, Operating rooms and Neonatal Intensive Care Unit and patients on dialysis.

~~2.~~**3.** Personal pets are not permitted in the hospital unless they are a service animal or an approved Pet Therapy dog:

a. Exceptions shall be made through hospital administration with consultation from Infection Control.

b. Strict guidelines and criteria for approved Pet Therapy handlers and their dogs are outlined in the reference listed below.

~~2.~~**4.** **Only Active members of Tender Loving Canines (TLC) Program~~. Dogs~~ are authorized to perform service with dogs and handlers who are registered with Pet Partners, Independent Therapy Dogs, Inc., or other therapy dog certifying agencies approved by ~~Tri-City Medical Center~~TCHD.**

~~3.~~**5.** Pet Therapy dogs ~~and their handlers~~ must be wearing visible blue vests and ~~TCMC~~ **TCHD** identification name badges with their name and "Pet Therapy." **Small Dogs that cannot be fitted with a vest should wear the TC~~M~~CHD bandana only.**

~~3. The Manager / Assistant Nurse Manager (ANM) or designee can access a copy of the guidelines, policies, and procedures for Pet Therapy from Rehab Services on the intranet.~~

~~4.~~**6.** Any problems identified with Pet Therapy pets or their handlers shall be directed to the Manager /~~-~~**Assistant Nurse Manager** (ANM) or designee.

a. These concerns shall be directed to the Therapeutic Recreation **Specialist/~~-~~Pet Therapy Coordinator** ~~Representative~~ at extension 7387 for follow-up and resolution.

~~5.~~**7.** Patients shall be provided with hand hygiene product to wash their hands after a visit.

8. Any handler who does not follow proper procedures or a dog that appears to be out of control ~~may~~ **will** be asked to leave the hospital premises immediately with notification to the ~~Pet Therapy Coordinator~~**Therapeutic Recreation Specialist/~~-~~Pet Therapy Coordinator** at extension 7387.

9. Dog's Equipment:

a. Well-fitted buckle, quick-release connection, or snap closure ~~red~~blue collar and harness made of leather or fabric~~.~~

i. All metal/chain or slip collars may not be used.

ii. Special training collars such as pinch, spike, electric or spray may not be used.

b. Collars may be flat collars or Martingales (i.e. limited slip collar).

c. Halters may be Gentle Leader, Promise, Snoot Loop or Halti and may only be used at the discretion of the animal behaviorist.

i. Metal chain and retractable leashes may not be used (~~i~~ei.e. Flexi-Leash).

d. Metal buckles, slip rings, and D-rings are acceptable.

e. All ~~leather or fabric red~~ leashes~~,~~ to ~~no~~be no more than 6' in length.

10. Handler's Attire:

a. Clothing:

i. Clothes are to be neat and tidy and may not include shorts, blue jeans, short skirts or tight-fitting clothing.

ii. Shoes must be closed-toed.

iii. No accessories or jewelry that may have sharp edges or corners.

b. TLC Uniforms:

i. TLC approved attire is to be worn by handler at all times when present in the facility on a visit with their dog.

ii. TC~~M~~CHD identification (ID) badge and Pet Therapy ID badge from approved TC~~M~~CHD Pet Therapy certification/registration agency, both to be worn at all times

C. PROCEDURE:

1. General Guidelines:

a. All handlers must be at least eighteen (18) years of age.

b. TLC is the only group sponsoring pets in the hospital that is supported by the medical staff. Dogs that have not been screened are not sponsored by TLC in the hospital. Dogs must be at least one year of age to start in the program and have been with the handler for at least 6 months.

c. Handler is required to become a member of the TC~~M~~CHD Auxiliary, which includes the following:

i. Yearly membership dues

ii. Background check
iii. Influenza Vaccination
iv. Tuberculosis (TB) screening
v. Hospital Orientation
vi. Annual auxiliary refresher course

d. Admittance to the TLC program requires a TC~~MC~~HD ~~approved process, each step of which must be fully completed for the application to be accepted. The procedure consists of the following process:~~approval and supervision by Therapeutic Recreation Specialist/~~Pet Therapy Coordinator~~/ Pet Therapy Coordinator.

e. Health tests are required for the handler ~~and~~, per TC~~MC~~HD volunteer policy for health screening and dog, signed off by veterinarian, per attached form and ~~fleas~~submitted to ~~Pet Therapy Coordinator~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator.

f. The Handler will complete a ~~Tri-City Medical Center~~TCHD Pet Therapy application form and submit to the ~~Pet Therapy Coordinator~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator, pending approved trainee status. Certification/registration documents from Pet Partners, Independent Therapy Dogs, Inc., Love on a Leash or other therapy dog certifying agency approved by ~~Tri-City Medical Center~~TCHD must be included with the application.

g. All trainee members (handlers and dogs) will attend an orientation meeting prior to beginning hospital work conducted by ~~Pet Therapy Coordinator~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator:

h. Trainee handlers and their dogs should be accompanied by a certified handler and Therapeutic Recreation Specialist/ Pet Therapy Coordinator ~~or trained observer~~ for a minimum of three (3) consecutive visits within 3 months of being accepted into the TLC program. Appropriateness of their behavior and awareness of TC~~MC~~HD policies will be assessed before being scheduled to make visits on their own to units. The visits will include one visit to the unit on which they will be volunteering. ~~A trained observer is anyone who has received approval from the TLC Pet Therapy Coordinator~~~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator~~.

i. On a yearly basis, the dog must pass the above-mentioned physical exam for membership renewal.

2. Scheduling by the TC~~MC~~HD ~~Pet Therapy Coordinator~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator:

a. Handlers will coordinate and schedule visits with ~~Pet Therapy Coordinator~~Therapeutic Recreation Specialist/ Pet Therapy Coordinator.

b. Any aggressive behavior will be grounds for suspension. All dogs involved may be suspended by the Therapeutic Recreation Specialist/ Pet Therapy Coordinator for up to three months pending investigation. Investigation of the incident will be conducted by the Therapeutic Recreation Specialist/Pet Therapy Coordinator, Risk Management Officer &and Security Staff as needed. Upon investigation, the Committee will determine necessary steps for further training or dismissal of the involved team from the Pet Therapy Program,

c. Return of the team to the TLC program, will be based on assessment and training by a nationally certified dog trainer, approved by TC~~MC~~HD Pet Therapy Coordinator.

~~B. RELATED DOCUMENTS:~~

~~C.~~3. ~~Pet Therapy Certification Criteria 2016~~Rehabilitation Services Policy Manual Standard ~~Number V.N.4.c Pet Therapy – Tender Loving Canines~~

D. REFERENCE(S):

1. Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities. *Recommendations of CDC and the Healthcare Infection Control Practice Advisory Committee (HICPAC).* MMWR 2003; 52 (No.RR-10); 1-48.
~~6.~~2. Lafebre et al. (2008). *Guidelines for animal assisted intervention in health care facilities.* AJIC, 36(2). P 78-85.
3. Medical Evaluation Form for Dogs and Cats. Development, Implementation, and Evaluation of Animal-Facilitated Therapy Programs, Delta Society Conference, Oct. 4-6,~~1988~~, 1988.
~~7.~~4. Pet Therapy Certification Criteria 2016
5. Prescription Pet Program, ~~The~~the Children's Hospital, Denver, Colorado. Veterinary Health Protocol, Initial Behavioral Evaluation, Assn. of Volunteers for Children's Hospital and the Denver Area Veterinary Medical Society, Sept. 1987.
6. Proposal for Health Examination/Screening of Dogs - Pilot Pet Therapy Program. Barbara Deep, D.V.M., School of Animal Medicine, University of Washington, Oct. 1 1987.
7. Proposal to Provide Animal Assisted Therapy Services to Canyon Springs Hospital. Delta Society, California Desert Chapter, April 1989.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**11/02**	**SUBJECT:**	**Pre-Printed Orders**
REVISION DATE:	**12/02, 03/03, 02/04, 02/05, 11/06, 09/08, 06/11**	**POLICY NUMBER:**	**IV.M.1**

Department Review:	**07/17**
Clinical Policies & Procedures Committee Approval:	**~~08/14~~09/17**
Nursing Executive Council Approval:	**~~08/14~~09/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/14~~10/17**
Professional Affairs Committee Approval:	**~~10/14~~11/17**
Board of Directors Approval:	**11/14**

A. **PURPOSE:**
1. To provide an approval process for Pre-Printed Orders (PPO).

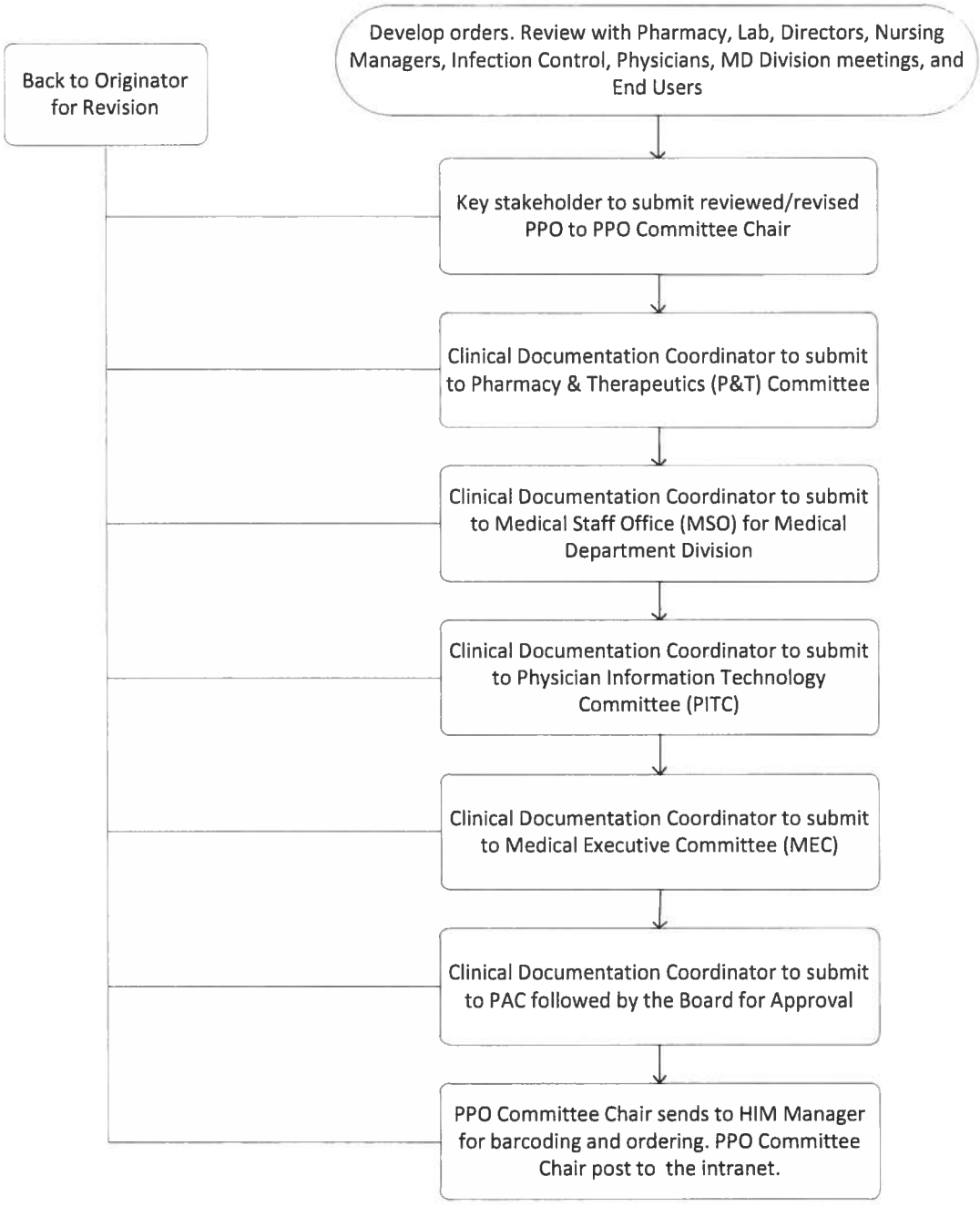
B. **DEFINITION(S):**
1. Powerplan: A grouping of orders that can be implemented together to facilitate the ordering process.

C. **POLICY:**
1. All ~~pre-printed orders~~**PPO** must be written in the approved Tri-City ~~Medical Center~~**Healthcare District** (~~TCMC~~**TCHD**) format, include an approved barcode, and go through the approval process.
2. All new ~~pre-printed orders~~**PPO** and requests for modifications of existing ~~pre-printed orders~~**PPO** will be submitted to the ~~Clinical Documentation Coordinator~~ **chair of the PPO Committee** to facilitate the approval process.
3. The ~~Clinical Documentation Coordinator~~ **PPO Committee** will ensure all ~~pre-printed orders~~**PPO** are reviewed (and modified if necessary) to meet organizational need and regulatory requirements (current requirement is once every three years).
4. Once approved by the Board, the p~~re-printed orders~~**PPO** shall be available on the ~~TCMC~~ **TCHD** Intranet.
5. See **Pre Printed Orders Approval Process** ~~attached~~ **for a** flow chart of **the** approval process ~~(Attachment A)~~.
6. PPO~~'s~~ ~~Pre-Printed orders~~ shall not be created unless absolutely necessary if an appropriate Powerplan does not exist or is not appropriate to be created at this time.
7. ~~All PPOs must be reviewed and approved every 3 years.~~

D. ~~**FORMS (LOCATED IN THE PATIENT CARE SERVICES MANUAL; FORMS FOLDER**~~**RELATED DOCUMENT(S):**
1. Pre Printed Orders Approval Process

Pre Printed Orders Approval Process

PRE-PRINTED ORDERS APPROVAL PROCESS



Revised 09/17

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**03/85**	**SUBJECT:**	**Referrals to Social Services for Patients Identified to be "High Risk"**
REVISION DATE:	**05/91, 06/94, 09/99, 06/03, 01/04, 02/07, 05/10, 08/11**	**POLICY NUMBER:**	**III.D.1**

Department Approval:	**09/17**
Clinical Policies & Procedures Committee Approval:	**~~07/11~~09/17**
Nursing Executive Council Approval:	**~~08/11~~09/17**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/11~~10/17**
Professional Affairs Committee Approval:	**~~09/11~~11/17**
Board of Directors Approval:	**09/11**

A. **PURPOSE:**

1. Hospitalization represents a crisis to most patients. Social and emotional problems are usually present at the time of admission and frequently complicate a patient's hospital stay, particularly if the patient is in a high-risk category. High-risk patients need to be identified and referred to the Social Service Department as early in the hospital stay as possible.

B. **DEFINITION(S):**

1. High-risk screening criteria:
   - **a.** Recent victim of violence/abuse /neglect
   - **~~a.~~b.** **Suspected abuse or neglect**
   - **~~b.~~c.** Demonstrating poor coping with illness/hospitalization
   - **~~c.~~d.** Demonstrating inadequate support systems
   - **~~d.~~e.** New~~ly diagnosed~~ cancer **diagnosis, progressive cancer** or **other** life-altering illness
   - **f.** ~~Diagnosed with~~ Terminal illness **diagnosis**
   - **~~e.~~g.** **Family conflict issues**
   - **~~f.~~h.** Current or recent substance abuse
   - **~~g.~~i.** Positive toxicology screen
   - **~~h.~~j.** Repeated Emergency Department visits
   - **~~i.~~k.** Intent to leave **Against Medical Advice** (AMA)
   - **~~j.~~l.** Homeless
   - **~~k.~~m.** **Fourteen** (14) **to twenty** (20) year old adolescent~~s~~
   - **~~l.~~n.** Pregnant/ near term and no prenatal care (including teen mothers)
   - **~~m.~~o.** Failure to thrive (infant)
   - **~~n.~~p.** NICU admit
   - **~~o.~~q.** **Prospective** adoption,~~/~~ foster placement
   - **~~p.~~r.** Surroga**cyte ~~mother~~**
   - **~~q.~~s.** Fetal demise
   - **t.** Developmental disability **or cognitive impairment including dementia or suspected dementia and** not connected with appropriate community resources
   - **u.** **Any patient with a hospital Length of Stay (LOS) greater than seven days**
   - **~~r.~~v.** **Patients readmitted to the hospital within thirty (30) days**
2. Notify Assistant Nurse Manager/RN to arrange for psychiatric consultation if:
   - a. Recent suicide attempt
   - b. **Suspected** psychiatric disorder/behavior problem

c. **Suspected** psychiatric/behavior disorder (i.e., depressed, suicidal, acting out, etc.)
~~c.~~**d.** **Cognitive/behavioral issue including dementia or suspected dementia presenting a barrier to safe and appropriate discharge**

C. **POLICY:**

1. High-risk patients are identified in the following ways:
   a. Upon admission through use of the Admission Assessment-Patient History.
   b. During interdisciplinary case review rounds or treatment team conferences held on all units where general high-risk indicators are identified and discussed.
   c. By a health care professional, physician, hospital personnel, community agency, or by patient, family or friend.
   d. Through case finding by the Social Worker within their particular areas of responsibility.
2. High-risk Social Service referral screens help to identify those patients needing priority services by social work staff.
3. If high-risk psychosocial factors are identified a referral is made by nursing to Social Services by selecting Referral to Social Services in the Admission Assessment – Patient History Power Form, or by placing an order for a Social Service referral in Powerchart.
4. Social Workers will make every effort to complete Social Work Assessments within **twenty-four** (24) business hours of receiving the referral.

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

~~4.~~**1.** **Patient Care Services: Referral to Social Services for Biopsychosocial Assessment**

Tri-City Medical Center	Distribution: Patient Care	TRACKED CHANGES

PROCEDURE:	VENIPUNCTURE FOR SPECIMEN COLLECTION
Purpose:	To establish a standard of care for the process of venipunctures for blood specimen collection.
Supportive Data:	The RN/Phlebotomist needs to be prepared with the proper equipment and supplies. The RN/Phlebotomist must choose the best site for the phlebotomy; positioning both, the patient and themselves, to facilitate a successful blood draw. Proper specimen collection is of the utmost importance to assure quality laboratory specimens.
Equipment:	1. Safety needles: Syringe, Multidraw Vacutainer and Butterfly and Blood Transfer Device, **Luer-lok access device** 2. Plastic Holder used for Vacutainer needles 3. Syringes – Sterile and non-sterile 4. Vacuum Tubes **within expiration dates** a. Blood Cultures b. Blue Stopper (sodium citrate) c. Red Stopper (no additive) d. Green Stopper (lithium heparin) e. Lavender Stopper (EDTA) f. Gray Stopper (sodium fluoride) 5. Tourniquets: a. Pre-cut tourniquet, a soft pliable non-latex bandage that is 1 inch wide and 15 inches long b. Blood pressure cuff 6. Antiseptics: **a.** 70% isopropanol (alcohol) **b. Chloraprep (Chlorhexidine Gluconate)** ~~a.~~**c. 2% Iodine Tincture SEPP** **7.** ~~Prepackaged~~ **Non-sterile** gauze pads: ~~b.~~**a. NICU: Saline Wipes** ~~7.~~**8.** Puncture resistant disposal container ~~8.~~**9.** Adhesive bandages or Co-Flex flexible bandage, **or gauaze and paper tape** **10.** Non-latex gloves: ~~9.~~**11. Blood Bank Armband if blood product(s) ordered**

A. POLICY:

1. **Non-Laboratory drawn specimens (by venipuncture only; excludes line draws) will be accepted by the laboratory if properly labeled blood specimen. Blood Cultures and Blood Bank Specimens will be accepted as follows:**

Department	Blood Cultures	Blood Bank Specimens	Comments
Dialysis	no	With phlebotomist present at bedside	
Cardiac Cath Lab (CCL)	no	With phlebotomist present at bedside	
Emergency Dept (ED)	no	With phlebotomist present at bedside	
Neonatal Intensive Care (NICU)	~~no~~yes	With phlebotomist present at bedside	
Intensive Care Unit (ICU)	no	With phlebotomist present at bedside	
Nursery			PKU only
Operating Room Pre-op Hold	yes	Yes with properly labeled transfusion armband number	

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Department of Pathology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
09/06, 10/10, 05/14, 04/17	10/10, 05/14, 06/17	11/10, 05/14, 07/17	08/17	11/10, 06/14, 09/17	01/11, 07/14, 10/17	01/11, 07/14

Labor & Delivery (L&D)	**no**	**Yes with properly labeled transfusion armband number**	
Physician Offices	**yes**	**Yes with properly labeled transfusion armband number**	

a. The phlebotomist must present at the bedside for blood bank specimens obtained by line draw.
b. The first blood culture may be obtained by line draw with physician order, and the second blood culture collection must be performed by venipuncture.

B. PROCEDURE:

1. Stoplight- read patient notices at the door or at the bedside.
2. Choose the appropriate PPE. ~~(contact precaution)~~
3. Introduce yourself, your reason of visit and your department.
~~2.~~**4.** Identify the patient using two identifiers depending on inpatient or outpatient status ~~(for more information on patient identification, please~~ . **R**efer to Patient Care Services ~~Policy~~: ~~IV.1.A,~~ Identification, Patient **Policy**~~). Verify that tube labels match patient's armband.~~
~~a. Labeling Policy:~~
~~i. Each sample must be accurately labeled at the bedside.~~
~~1) Samples labeled with the wrong patient name or those without labels cannot be used. These samples must be re-collected.~~
~~ii. Each tube of blood must be labeled with the patient's full name, medical record number, time and date the specimen was collected, and the Cerner code.~~
~~iii. Each tube must be labeled with a Laboratory Information System (LIS) label, patient label, or hand-written label with the following information:~~
~~1) Patient's full name~~
~~2) Medical record number~~
~~3) Time and date of specimen collection~~
~~4) Name or initials of nurse collecting specimen~~
5. Verify patient diet restrictions have been followed if applicable.
6. Select Needle, System, and Collection Tubes:
a. Select the appropriate type of needle and equipment for the blood draw based on the patient's physical characteristics and the amount of blood to be drawn.
i. Vacutainer System: It is generally preferable to use the needle and syringe because it allows the blood to pass directly from the vein in the tube.
ii. Plastic Syringe: In general, a syringe is used when drawing a specimen from individuals with fragile, thread or "rolly" vein walls and is used in conjunction with blood transfer device.
iii. Butterfly Needle System: The butterfly system is used on infants and extremely difficult patients.
~~3.~~**7.** Perform hand hygiene and don gloves.
8. Provide patient education which may include:
a. Although slightly painful, the venipuncture will be of short duration.
b. Blood cultures require 2 separate draws (when applicable).
c. Provide expectations for future repeat draws.
9. Position the patient:
a. Sitting patient:
i. Have the patient position his or her arm on the slanting on a slanting armrest and extend the arm to form a straight line from the shoulder to the wrist with no bend at the elbow.
b. Lying down patient:
i. Ask the patient to lie on his or her back in a comfortable position.
ii. Have the patient extend his or her arm to form a straight line from the shoulder to the wrist.
iii. Place a pillow under the arm if additional support is needed.
c. No food, thermometer or chewing gum should be in the patient's mouth.

10. Select site for venipuncture:
    a. First choice is the arm without an intravenous (IV) access.
    b. Although the larger and fuller median cubital and cephalic veins are used most frequently, wrist and hand veins are also acceptable for venipuncture.
    c. Factors to consider in site selection:
        i. Extensive scarring: avoid burn areas
        ii. Mastectomy: specimens from this side may not be a representative specimen.
            1) In emergency situation, you may proceed without physician/Allied Healthcare Professional (AHP)'s order.
            2) For bilateral mastectomy, get approval from ordering physician/ ~~Allied Healthcare Professional (AHP),provider~~ then select site based upon their recommendation.
        iii. Hematoma: may cause erroneous test results. If not other site available, collect specimen below the hematoma
        iv. Cannula, Fistula, Vascular Graft: use a cannulated arm only after consulting with the attending physician/AHP
        ~~Blood drawn from the Arterial line (A-line)~~
        ~~Blood may be drawn from the A-line while patient is being infused~~
        ~~A-line collection must be done by the nurse~~
        ~~A phlebotomist will assist~~
        v. Foot draw:
            1) Must not be attempted as a routine collection site, other than NICU.
            2) A physician/AHP must give written permission before this procedure is started.
        vi. A finger stick may be possible for some tests if no other site available.
        vii. The nurse or physician/AHP may ~~disconnect the IV and~~ draw blood through the needle or catheter following insertion of IV catheter~~that is already in place~~.
        ~~The IV must be off for a minimum of 3 minutes~~
        ~~Do not apply tourniquet until the 3 minute period is over~~
        ~~The first 3-5 mLl of this sample must be discarded~~
        ~~This is not an acceptable method for a PT, PTT or if the IV is infusing blood or blood products~~
        viii. Blood transfusions:
            1) It is preferable to wait until the transfusion is completed before the blood is drawn, but orders regarding the timing of the blood draw would be followed.
            2) When specimens are collected during the time that blood is being transfused, a comment "drawn during TXN" should be entered in the computer after each test.
    d. If a patient has bilateral IV sites or the only arm available has an IV site:
        i. Never place a tourniquet or draw above an active IV site.
        ii. The site should be as far as possible below (distal) ~~from~~ the IV.
        iii. When the site is within 3 inches of the active IV, the phlebotomist will need to free-text "DRAWN BELOW BUT NEAR IV" in the computer after each test.
            1) Venipuncture above an inactive heparin lock is acceptable.
    e. Close the patient's hand to make veins more prominent and easier to enter.
        i. Avoid having the patient pump the hand which can cause the release of potassium from the muscle tissue.
    f. Palpate and trace the path of veins several times with the index finger.
        i. Arteries pulsate, are more elastic and have a thick wall.
        ii. Thrombosed veins lack resilience, feel cordlike and roll easily.
        iii. Lowering the extremity will allow the veins to fill to capacity.

iv. **If superficial veins are not readily apparent, massage the arm from the wrist to the elbow to force blood into the vein wall.**
v. **Tapping sharply at the vein site with the index finger a few times will cause the vein to dilate.**
vi. **Applying a warming device, ~~damp washcloth~~ to the site for 4 minutes may have the same result.**

11. Cleanse the venipuncture site with an alcohol pad using a circular motion from the center to the periphery. Allow area to dry.
    a. **For NICU infants:**
        i. **Disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU).**
        ii. **Wipe away all disinfectant with saline wipe after procedure is complete.**
        iii. **Alcohol should not be utilized for NICU infants.**
    ~~2.~~b. **Drying prevents the patient from having a burning sensation when the venipuncture is preformed and hemolysis of the specimen.**
12. Apply the tourniquet:
    a. **Wrap the tourniquet around the arm three to four inches above the venipuncture site.**
    b. **The tourniquet should be tight but not painful.**
    c. **The tourniquet should be released after no more than one minute.**
    d. **If the tourniquet must be applied for preliminary vein selection, it should be released and reapplied after two minutes.**
    e. **When drawing a Lactic Acid level:**
        i. **With other labs, collect the lactic acid level last and remove tourniquet before collection.**
        ii. **Without other labs do not use tourniquet.**
13. Inspect the Needle and Syringe:
    a. **Visually determine that the needle is free of hooks at the end of the point and free from small particles that could restrict the flow.**
    ~~3.~~b. **Move the plunger within the barrel of the syringe to show syringe and needle patency and freedom of plunger movement.**
14. Perform the Venipuncture:
    a. **With thumb and forefinger, secure the vein by placing the forefinger 1 to 2 inches above the venipuncture site and the thumb just below the site.**
    b. **If unable to obtain a blood sample:**
        i. **Change the position of the needle.**
            1) **If the needle has penetrated too far into the vein, pull it back a bit.**
            2) **If it has not penetrated the vein far enough, advance it farther into the vein.**
        ii. **Try another tube, the tube being used may not have sufficient vacuum.**
        ~~Loosen the tourniquet~~
        iii. **Probing is not recommended.**
        ~~4.~~iv. **Loosen the tourniquet, it may have been applied too tightly thereby stopping the blood flow.**
    c. If **Registered Nurse** (RN)/Phlebotomist is unsuccessful after 2 attempts, it is suggested that he or she shall contact another person to attempt venipuncture.
    d. **Factors to consider during venipuncture:**
        i. **To prevent hematoma:**
            1) **Puncture only the uppermost wall of the vein**
            2) **Remove the tourniquet before removing the needle**
            3) **Use major superficial veins**
        ii. **To prevent hemolysis:**
            1) **Mix anticoagulated specimens thoroughly by inverting tubes gently 5 to 10 times**
            2) **Avoid drawing blood from a hematoma**

3) **Avoid drawing the plunger back too forcefully when using a needle and syringe**
4) **Avoid using a needle that is too small**
5) **Make sure the needle is fitted securely on the syringe to avoid frothing**
~~a.~~6) **Without touching, ascertain that the venipuncture site is dry**

4.**15.** Vacuum Method:
a. Thread the appropriate needle into the vacutainer holder until it is secure.
b. Tap all the tubes that contain additives to ensure that the entire additive is dislodged from the stopper and the wall of the tube.
c. Tube order for multiple collection draws:
i. Blood Culture **Bottles**~~Tube~~ **(Aerobic and Anaerobic)**
ii. Blue stopper (sodium citrate)
iii. Red stopper (non additive)
iv. Green stopper (lithium heparin)
v. Lavender stopper (EDTA)
vi. Gray stopper (oxalate/sodium fluoride)
d. Insert the blood collection tube into the holder and onto the needle up to the recessed guideline on the needle holder. Do not push the tube beyond the guideline.
~~b.~~**i. Do not preassemble supplies outside the patient area.**
~~d.~~**e.** With the bevel up, line up the needle with the vein. The needle should be held in one hand at a 15 to 30° angle to the arm. Penetrating the vein at the proper angle will prevent penetrating both blood vessel walls. The skin and vein should be entered in one smooth motion until the~~n~~ needle is in the center of the vein. Push the tube forward until the end of the needle punctures the stopper. Blood should flow immediately into the tube.
~~e.~~**f.** Fill the tube until the vacuum is exhausted and blood flow ceases. This will ensure that there is a correct ratio of anticoagulant to blood.
~~f.~~**g.** When the blood flow ceases, remove the tube from the holder. The shut-off valve recovers the point, stopping blood flow until the next tube is inserted.
~~g.~~**h.** Mix immediately after drawing each tube that contains an additive by gently inverting the tube 5 to 10 times. To avoid hemolysis, do not mix vigorously.
~~h.~~**i.** To obtain additional specimens, insert **the** next tube into holder. When the proper amount of blood has been obtained, the tourniquet should be released and patient's hand opened.
~~i.~~**j.** Before removing the needle from the vein, pull back slightly on the tube to release any remaining vacuum left in the tube.
~~j.~~**k.** The needle may then be withdrawn from the vein while gauze is placed over the puncture site.
~~k.~~**l.** Engage the safety mechanism on the needle. Dispose directly into sharps container.

5.**16.** Syringe and needle method:
a. Insert the appropriate safety needle onto the syringe.
b. Place the patient's arm in a downward position if possible.
c. Line up the needle and syringe with the vein from which the blood will be drawn.
d. Turn the needle so ~~that~~ the bevel is in an upward position.
e. Push the needle into the vein.
f. Pull back on the syringe plunger until the desired amount of blood has been obtained.
g. Release the tourniquet and open the patient's hand.
h. The needle may now be withdrawn from the vein while gauze is placed over the venipuncture site.
i. Lock the safety mechanism of the needle into place. Remove the needle from the syringe ~~by using a hemostat~~ and dispose of the needle into the sharps container.
i. Note: Never transfer blood by inserting the needle directly into the vacuum tubes.
~~i.~~**j.** Attach a blood transfer device to the tip of the syringe and insert the vacuum tubes in order of blood draw to transfer the blood into the tubes.

~~j.~~**k.** Gently mix tubes by inversion after transferring the blood into the tubes.
~~k.~~**l.** Dispose of the syringe and transfer device into the sharps container.

~~6.~~**17.** Venipuncture using a butterfly needle:
a. Attach appropriate syringe or vacutainer holder to tubing.
b. Follow standard venipuncture technique until needed amount of blood is obtained.
c. Follow proper process for needle withdrawal.
d. Remove butterfly, engage safety mechanism on the needle, and dispose in a sharps container.
i. If syringe method is used, attach a blood transfer device to the syringe and fill the appropriate tubes with blood as outlined above.

18. Coagulation Studies:
a. ~~Test and Tube Type~~In-House Routine Tests:
i. All the tests below are collected in a 2.7 ml sodium citrate (blue top) vacuum tube.
1) PT~~B~~ (Prothrombin time and INR)
2) PTT
3) Fibrinogen
4) D-Dimer
5) TT (Thrombin Time)
6) ~~Factor Assay and~~ 1:1 Mixing Studies
ii. DIC screens (Includes PT/INR, PTT, Fibrinogen, FDP, D-dimer, Platelet Count and smear for schistocytes) require:
1) 2.7 ml Sodium Citrate tube (Blue Top)
2) EDTA tube (Lavendear Top)
b. In House Special Tests:
i. The coagulation Department will provide tubes for the following tests:
1) Infant Coagulation Studies: The coagulation Department will prepare special tubes for all children less than 1 year of age.
c. Send out Special Coagulation Tests:
i. The following will be drawn in ~~3.5~~three (3) 2.7 ml sodium citrate (Blue Top) tubes:
1) AT3 (Antithrombin III)
2) Protein C
3) Protein S
4) Activated Protein C Resistant Factor V
5) Factor Assays
6) Hemostasis A Panel
d. Special Considerations:
i. It is very important to perform an atraumatic venipuncture, because any tissue fluid contamination will activate the clotting system.
ii. It is critical that all tubes be filled to the required capacity. Overfilled tubes may clot and under filled tubes will give a false result
iii. Line Draws: Coagulation studies are not to be drawn from A-lines unless ordered by a physician/AHP, except for NICU.
1) The first 10 mL of blood must be discarded before blood is used to fill the coagulation tubes
a) NICU: When utilizing venipuncture, do not discard any amount of specimen. Lines utilized for NICU Lab draws (in order of preference) should only be Umbilical Arterial Lines, Peripheral Arterial Lines, or Umbilical Venous lines.
2) Phlebotomist/NICU RN must inform the Coagulation Department if a line draw must be done for a coagulation test.
3) Must append a comment "line draw" to each test in the computer using FUNCTION: RE.

4) Heel sticks and finger sticks are not allowed under any circumstances.
5) Central Venous Access Devices: See Patient Care Service: ~~Procedure~~ Central Venous Access Devices, Adult Procedure.

iv. Syringe draw: The last blood into a syringe will offer the best results for coagulation tests, so fill the blue top first.
1) If only coagulation tests are ordered, draw an extra 1-2 mL to leave in the syringe.

v. Butterfly draw: If the coagulation tube is the only tube to be drawn, a small red top tube should be drawn with at least 1 mL before filling the citrate tube (Blue Top).

19. Blood Cultures:

a. Use appropriate equipment and draw appropriate volume of blood based on patient's age/weight:
i. Newborns (less than 4 kilograms [kg]):
1) Collect 1 mL of blood in a Peds Plus bottle from one site only.
ii. Children 2 years of age or less:
1) Collect 5 mL of blood in a Peds Plus bottle from one site only.
iii. Children 2-6 years of age or weighing 30 – 80 pounds (lbs):
1) Use one aerobic and one anaerobic bottles and collect 5 mL of blood for each bottle
iv. Adults and children weighing greater than 80 lbs:
1) Use 2 sets of aerobic and anaerobic bottles, each bottle containing 8-10 mL of blood.
2) Select a different venipuncture site for each blood culture.
a) If poor access requires that blood for culture be drawn through a port in an IV or indwelling catheter, the second must be drawn from a peripheral site as cultures drawn through catheters can indicate catheter colonization.
b) Do not draw blood from a vein into which an IV solution is infusing.
c) If venipuncture must be performed at the same site (usually due to bad veins), perform the second venipuncture at that site.

b. Once a site is selected, clean site as follows and avoid touching site after cleansing.
i. For adults, children, and infants greater than ~~6~~2 months old:
1) Using Chloraprep, ~~vigorously scrub the site~~cleanse with gentle, repeated back and forth strokes for 30 seconds and allow to dry.
~~For infants less than 6 months old, DO NOT USE Chloraprep.~~
~~Cleanse site with an alcohol prep pad and let it dry~~
~~Then cleanse with a 2% iodine tincture (SEPP) using concentric circles and let it dry (clarify)~~
2) For infants less than 2 months old and NICU infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU). Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for NICU infants.

c. Use a new needle with each venipuncture attempt.
i. Do not palpate the skin after it is disinfected.

d. Pop the cap of the blood culture bottle and inoculate first the aerobic bottle and then the anaerobic bottle with the appropriate amount of blood.
i. If the cap has been off the blood culture bottle for any amount of time, the rubber stopper on the bottle must be cleaned with an alcohol prep pad.
ii. For direct inoculation into the bottles from the needle apparatus, mark the side of the bottle with the recommended draw.

1) **For ~~anaerobic~~ Aerobic bottles, mark 3rd lines down from top of bottle.**
2) **For anaerobic bottles, mark 2nd lines down from top of bottle.**

iii. **If using a needle and syringe, use the volume markings on the syringe to note the volume.**
1) **Hold the syringe plunger during transfer to avoid transfer of excess blood into bottles having ~~a~~ significant vacuum.**

iv. **There is no need to change the safety device between inoculations.**

~~7.~~**20.** Bandage the site:
a. Patients not on anticoagulants:
i. Apply tape or an adhesive over the venipuncture site after checking ~~to be sure~~ that all bleeding has stopped. Ask the patient to leave the pressure dressing on for at least 30 minutes.
ii. If the patient continues to bleed, apply pressure to the site with a gauze pad until the bleeding stops. Then apply clean folded gauze as a pressure dressing to the site. Ask the patient to leave on the bandage for at least one hour.
b. Patients on anticoagulants:
i. Apply pressure for 2 minutes and then check for bleeding.
ii. Watch the venipuncture site for an additional 30-second interval until bleeding has stopped.
iii. Place clean gauze pad on the site and tape to create a pressure bandage.
1) Note: Patients on tPA will require additional pressure up to 20 minutes.

~~8.~~**21.** Disposal of Needle: ~~Never clip, bend, recap, unscrew, or otherwise manipulate a needle by hand~~
a. Dispose~~al~~ of needles promptly to prevent their reuse or accidental injury. The vacutainer needle and vacutainer holder assembly are disposed of in the sharps container. The syringe and needle should all be discarded in the sharps container.
i. Note: The vacutainer needle and holder will never be reused.
~~c.~~**ii. Never clip, bend, recap, unscrew or otherwise manipulate a needle by hand.**

22. Labeling:
a. **Refer to Patient Care Services: Specimen Labeling Procedure.**

~~9.~~**23.** Specimen Handling:
a. Follow any special specimen handling requirements for the specimens drawn such as protecting from light, placing on ice, or keeping at body temperature.

~~10.~~**24.** Specimen Transport:
a. When transporting from patient location to the Lab, place the specimens in a secondary container.
b. When using the pneumatic tube system, place the specimens in a zip lock, leak proof bag with the requisition or labels in the side pocket or clipped to the outside of the bag.

C. RELATED DOCUMENT(S):

1. **Order of Draw**
2. **Patient Care Services: Central Venous Access Devices Procedure**
3. **Patient Care Services: Identification, Patients Policy**
4. **Patient Care Services: Specimen Labeling Procedure**

~~B.~~D. REFERENCE(S):

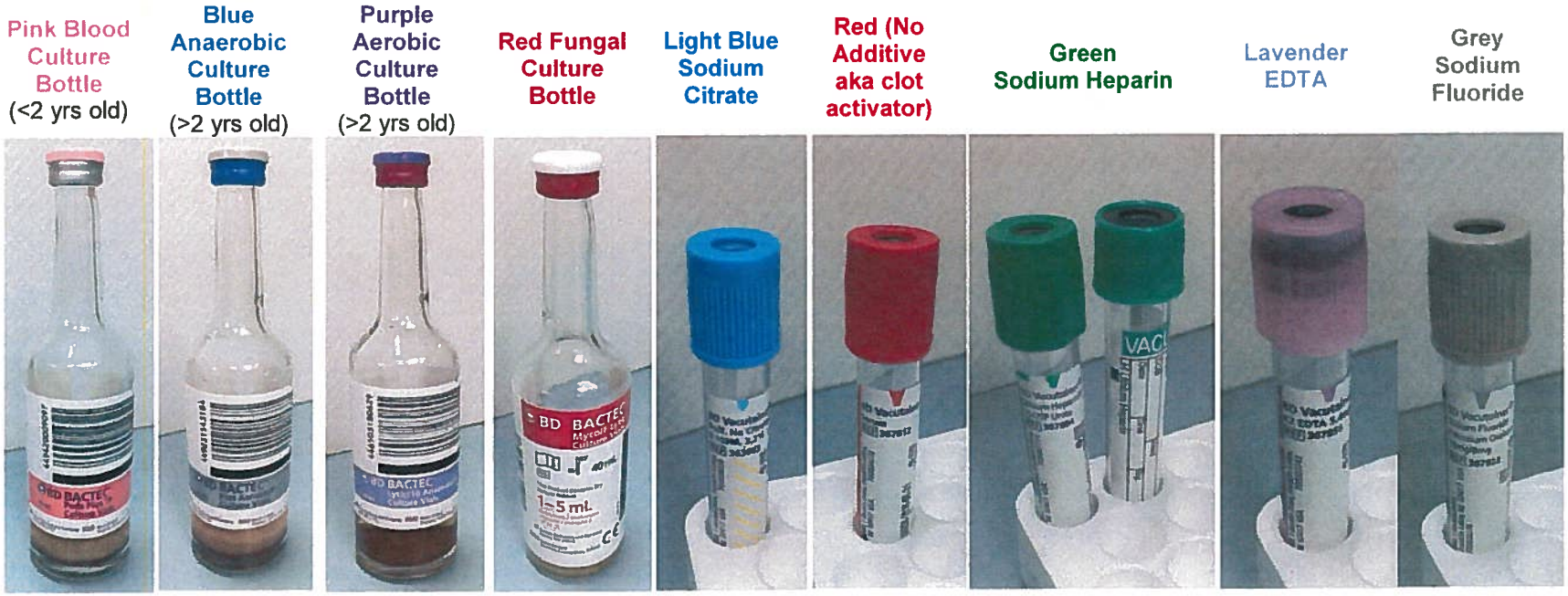
1. **CLSI (2010) Procedures for the Handling and Processing of Blood Specimen for Common Laboratory Tests; Approved Guideline – Fourth Edition. CLSI document GP44-A4. Wayne, PA: Clinical and Laboratory Standards Institute**
~~1.~~**2. CLSI (2010) Tubes and Additives for Venous and Capillary Blood Specimen Collection; Approved Standard – Sixth Edition. CLSI document GP39-A6. Wayne, PA: Clinical and Laboratory Standards Institute**

~~2.~~3. **CLSI (2017) Collection of Diagnostic Venous Blood Specimens. 7th ed. CLSI standard GP41. Wayne, PA: Clinical and Laboratory Standards Institute**
~~NCCLS Document H3-A5, (5th ed.) (2003). Procedure for the collection of diagnostic blood specimen by venipuncture Approved Standard.~~

4. **CLSI (2017) Essential Elements of a Phlebotomy Training Program. 1st ed. CLSI document GP48. Wayne, PA: Clinical and Laboratory Standards Institute**

~~3.~~5. ~~OSHA Regulations 29CFR Blood Borne Pathogens 1910.1030~~

Order of Draw



Tri-City Medical Center	Distribution: Patient Care	CLEAN COPY

PROCEDURE:	VENIPUNCTURE FOR SPECIMEN COLLECTION
Purpose:	To establish a standard of care for the process of venipunctures for blood specimen collection.
Supportive Data:	The RN/Phlebotomist needs to be prepared with the proper equipment and supplies. The RN/Phlebotomist must choose the best site for the phlebotomy; positioning both, the patient and themselves, to facilitate a successful blood draw. Proper specimen collection is of the utmost importance to assure quality laboratory specimens.
Equipment:	1. Safety needles: Syringe, Multidraw Vacutainer and Butterfly and Blood Transfer Device, Luer-lok access device 2. Plastic Holder used for Vacutainer needles 3. Syringes – Sterile and non-sterile 4. Vacuum Tubes within expiration dates a. Blood Cultures b. Blue Stopper (sodium citrate) c. Red Stopper (no additive) d. Green Stopper (lithium heparin) e. Lavender Stopper (EDTA) f. Gray Stopper (sodium fluoride) 5. Tourniquets: a. Pre-cut tourniquet, a soft pliable non-latex bandage that is 1 inch wide and 15 inches long b. Blood pressure cuff 6. Antiseptics: a. 70% isopropanol (alcohol) b. Chloraprep (Chlorhexidine Gluconate) c. 2% Iodine Tincture SEPP 7. Non-sterile gauze pads: a. NICU: Saline Wipes 8. Puncture resistant disposal container 9. Adhesive bandages or Co-Flex flexible bandage, or gauze and paper tape 10. Non-latex gloves: 11. Blood Bank Armband if blood product(s) ordered

A. **POLICY:**

1. Non-Laboratory drawn specimens (by venipuncture only; excludes line draws) will be accepted by the laboratory if properly labeled blood specimen. Blood Cultures and Blood Bank Specimens will be accepted as follows:

Department	Blood Cultures	Blood Bank Specimens	Comments
Dialysis	no	With phlebotomist present at bedside	
Cardiac Cath Lab (CCL)	no	With phlebotomist present at bedside	
Emergency Dept (ED)	no	With phlebotomist present at bedside	
Neonatal Intensive Care (NICU)	yes	With phlebotomist present at bedside	
Intensive Care Unit (ICU)	no	With phlebotomist present at bedside	
Nursery			PKU only
Operating Room Pre-op Hold	yes	Yes with properly labeled transfusion armband number	

Department Review	Clinical Policies & Procedures	Nurse Executive Committee	Department of Pathology	Medical Executive Committee	Professional Affairs Committee	Board of Directors
09/06, 10/10, 05/14, 04/17	10/10, 05/14, 06/17	11/10, 05/14, 07/17	08/17	11/10, 06/14, 09/17	01/11, 07/14, 10/17	01/11, 07/14

Labor & Delivery (L&D)	no	Yes with properly labeled transfusion armband number	
Physician Offices	yes	Yes with properly labeled transfusion armband number	

a. The phlebotomist must present at the bedside for blood bank specimens obtained by line draw.
b. The first blood culture may be obtained by line draw with physician order, and the second blood culture collection must be performed by venipuncture.

B. **PROCEDURE:**

1. Stoplight- read patient notices at the door or at the bedside.
2. Choose the appropriate PPE.
3. Introduce yourself, your reason of visit and your department.
4. Identify the patient using two identifiers depending on inpatient or outpatient status. Refer to Patient Care Services: Identification, Patient Policy
5. Verify patient diet restrictions have been followed if applicable.
6. Select Needle, System, and Collection Tubes:
   a. Select the appropriate type of needle and equipment for the blood draw based on the patient's physical characteristics and the amount of blood to be drawn.
      i. Vacutainer System: It is generally preferable to use the needle and syringe because it allows the blood to pass directly from the vein in the tube.
      ii. Plastic Syringe: In general, a syringe is used when drawing a specimen from individuals with fragile, thread or "rolly" vein walls and is used in conjunction with blood transfer device.
      iii. Butterfly Needle System: The butterfly system is used on infants and extremely difficult patients.
7. Perform hand hygiene and don gloves.
8. Provide patient education which may include:
   a. Although slightly painful, the venipuncture will be of short duration.
   b. Blood cultures require 2 separate draws (when applicable).
   c. Provide expectations for future repeat draws.
9. Position the patient:
   a. Sitting patient:
      i. Have the patient position his or her arm on the slanting on a slanting armrest and extend the arm to form a straight line from the shoulder to the wrist with no bend at the elbow.
   b. Lying down patient:
      i. Ask the patient to lie on his or her back in a comfortable position.
      ii. Have the patient extend his or her arm to form a straight line from the shoulder to the wrist.
      iii. Place a pillow under the arm if additional support is needed.
   c. No food, thermometer or chewing gum should be in the patient's mouth.
10. Select site for venipuncture:
   a. First choice is the arm without an intravenous (IV) access.
   b. Although the larger and fuller median cubital and cephalic veins are used most frequently, wrist and hand veins are also acceptable for venipuncture.
   c. Factors to consider in site selection:
      i. Extensive scarring: avoid burn areas
      ii. Mastectomy: specimens from this side may not be a representative specimen.
         1) In emergency situation, you may proceed without physician/Allied Healthcare Professional (AHP)'s order.
         2) For bilateral mastectomy, get approval from ordering physician/ AHP, then select site based upon their recommendation.
      iii. Hematoma: may cause erroneous test results. If not other site available, collect specimen below the hematoma

iv. Cannula, Fistula, Vascular Graft: use a cannulated arm only after consulting with the attending physician/AHP
v. Foot draw:
1) Must not be attempted as a routine collection site, other than NICU.
2) A physician/AHP must give written permission before this procedure is started.
vi. A finger stick may be possible for some tests if no other site available.
vii. The nurse or physician/AHP may draw blood through the needle or catheter following insertion of IV catheter.
viii. Blood transfusions:
1) It is preferable to wait until the transfusion is completed before the blood is drawn, but orders regarding the timing of the blood draw would be followed.
2) When specimens are collected during the time that blood is being transfused, a comment "drawn during TXN" should be entered in the computer after each test.

d. If a patient has bilateral IV sites or the only arm available has an IV site:
i. Never place a tourniquet or draw above an active IV site.
ii. The site should be as far as possible below (distal) the IV.
iii. When the site is within 3 inches of the active IV, the phlebotomist will need to free-text "DRAWN BELOW BUT NEAR IV" in the computer after each test.
1) Venipuncture above an inactive heparin lock is acceptable.

e. Close the patient's hand to make veins more prominent and easier to enter.
i. Avoid having the patient pump the hand which can cause the release of potassium from the muscle tissue.

f. Palpate and trace the path of veins several times with the index finger.
i. Arteries pulsate, are more elastic and have a thick wall.
ii. Thrombosed veins lack resilience, feel cordlike and roll easily.
iii. Lowering the extremity will allow the veins to fill to capacity.
iv. If superficial veins are not readily apparent, massage the arm from the wrist to the elbow to force blood into the vein wall.
v. Tapping sharply at the vein site with the index finger a few times will cause the vein to dilate.
vi. Applying a warming device, to the site for 4 minutes may have the same result.

11. Cleanse the venipuncture site with an alcohol pad using a circular motion from the center to the periphery. Allow area to dry.
a. For NICU infants:
i. Disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU).
ii. Wipe away all disinfectant with saline wipe after procedure is complete.
iii. Alcohol should not be utilized for NICU infants.
b. Drying prevents the patient from having a burning sensation when the venipuncture is preformed and hemolysis of the specimen.

12. Apply the tourniquet:
a. Wrap the tourniquet around the arm three to four inches above the venipuncture site.
b. The tourniquet should be tight but not painful.
c. The tourniquet should be released after no more than one minute.
d. If the tourniquet must be applied for preliminary vein selection, it should be released and reapplied after two minutes.
e. When drawing a Lactic Acid level:
i. With other labs, collect the lactic acid level last and remove tourniquet before collection.
ii. Without other labs do not use tourniquet.

13. Inspect the Needle and Syringe:

a. Visually determine that the needle is free of hooks at the end of the point and free from small particles that could restrict the flow.
b. Move the plunger within the barrel of the syringe to show syringe and needle patency and freedom of plunger movement.

14. Perform the Venipuncture:
    a. With thumb and forefinger, secure the vein by placing the forefinger 1 to 2 inches above the venipuncture site and the thumb just below the site.
    b. If unable to obtain a blood sample:
        i. Change the position of the needle.
            1) If the needle has penetrated too far into the vein, pull it back a bit.
            2) If it has not penetrated the vein far enough, advance it farther into the vein.
        ii. Try another tube, the tube being used may not have sufficient vacuum.
        iii. Probing is not recommended.
        iv. Loosen the tourniquet, it may have been applied too tightly thereby stopping the blood flow.
    c. If Registered Nurse (RN)/Phlebotomist is unsuccessful after 2 attempts, it is suggested that he or she shall contact another person to attempt venipuncture.
    d. Factors to consider during venipuncture:
        i. To prevent hematoma:
            1) Puncture only the uppermost wall of the vein
            2) Remove the tourniquet before removing the needle
            3) Use major superficial veins
        ii. To prevent hemolysis:
            1) Mix anticoagulated specimens thoroughly by inverting tubes gently 5 to 10 times
            2) Avoid drawing blood from a hematoma
            3) Avoid drawing the plunger back too forcefully when using a needle and syringe
            4) Avoid using a needle that is too small
            5) Make sure the needle is fitted securely on the syringe to avoid frothing
            6) Without touching, ascertain that the venipuncture site is dry

15. Vacuum Method:
    a. Thread the appropriate needle into the vacutainer holder until it is secure.
    b. Tap all the tubes that contain additives to ensure that the entire additive is dislodged from the stopper and the wall of the tube.
    c. Tube order for multiple collection draws:
        i. Blood Culture Bottles (Aerobic and Anaerobic)
        ii. Blue stopper (sodium citrate)
        iii. Red stopper (non additive)
        iv. Green stopper (lithium heparin)
        v. Lavender stopper (EDTA)
        vi. Gray stopper (oxalate/sodium fluoride)
    d. Insert the blood collection tube into the holder and onto the needle up to the recessed guideline on the needle holder. Do not push the tube beyond the guideline.
        i. Do not preassemble supplies outside the patient area.
    e. With the bevel up, line up the needle with the vein. The needle should be held in one hand at a 15 to 30° angle to the arm. Penetrating the vein at the proper angle will prevent penetrating both blood vessel walls. The skin and vein should be entered in one smooth motion until the needle is in the center of the vein. Push the tube forward until the end of the needle punctures the stopper. Blood should flow immediately into the tube.
    f. Fill the tube until the vacuum is exhausted and blood flow ceases. This will ensure that there is a correct ratio of anticoagulant to blood.

g. When the blood flow ceases, remove the tube from the holder. The shut-off valve recovers the point, stopping blood flow until the next tube is inserted.
h. Mix immediately after drawing each tube that contains an additive by gently inverting the tube 5 to 10 times. To avoid hemolysis, do not mix vigorously.
i. To obtain additional specimens, insert the next tube into holder. When the proper amount of blood has been obtained, the tourniquet should be released and patient's hand opened.
j. Before removing the needle from the vein, pull back slightly on the tube to release any remaining vacuum left in the tube.
k. The needle may then be withdrawn from the vein while gauze is placed over the puncture site.
l. Engage the safety mechanism on the needle. Dispose directly into sharps container.

16. Syringe and needle method:
    a. Insert the appropriate safety needle onto the syringe.
    b. Place the patient's arm in a downward position if possible.
    c. Line up the needle and syringe with the vein from which the blood will be drawn.
    d. Turn the needle so the bevel is in an upward position.
    e. Push the needle into the vein.
    f. Pull back on the syringe plunger until the desired amount of blood has been obtained.
    g. Release the tourniquet and open the patient's hand.
    h. The needle may now be withdrawn from the vein while gauze is placed over the venipuncture site.
    i. Lock the safety mechanism of the needle into place. Remove the needle from the syringe and dispose of the needle into the sharps container.
        i. Note: Never transfer blood by inserting the needle directly into the vacuum tubes.
    j. Attach a blood transfer device to the tip of the syringe and insert the vacuum tubes in order of blood draw to transfer the blood into the tubes.
    k. Gently mix tubes by inversion after transferring the blood into the tubes.
    l. Dispose of the syringe and transfer device into the sharps container.
17. Venipuncture using a butterfly needle:
    a. Attach appropriate syringe or vacutainer holder to tubing.
    b. Follow standard venipuncture technique until needed amount of blood is obtained.
    c. Follow proper process for needle withdrawal.
    d. Remove butterfly, engage safety mechanism on the needle, and dispose in a sharps container.
        i. If syringe method is used, attach a blood transfer device to the syringe and fill the appropriate tubes with blood as outlined above.
18. Coagulation Studies:
    a. In-House Routine Tests:
        i. All the tests below are collected in a 2.7 ml sodium citrate (blue top) vacuum tube.
            1) PT (Prothrombin time and INR)
            2) PTT
            3) Fibrinogen
            4) D-Dimer
            5) TT (Thrombin Time)
            6) 1:1 Mixing Studies
        ii. DIC screens (Include PT/INR, PTT, Fibrinogen, FDP, D-dimer, Platelet Count and smear for schistocytes) require:
            1) 2.7 ml Sodium Citrate tube (Blue Top)
            2) EDTA tube (Lavender Top)
    b. In House Special Tests:
        i. The coagulation Department will provide tubes for the following tests:
            1) Infant Coagulation Studies: The coagulation Department will prepare special tubes for all children less than 1 year of age.

c. Send out Special Coagulation Tests:
   i. The following will be drawn in three (3) 2.7 ml sodium citrate (Blue Top) tubes:
      1) AT3 (Antithrombin III)
      2) Protein C
      3) Protein S
      4) Activated Protein C Resistant Factor V
      5) Factor Assays
      6) Hemostasis A Panel

d. Special Considerations:
   i. It is very important to perform an atraumatic venipuncture, because any tissue fluid contamination will activate the clotting system.
   ii. It is critical that all tubes be filled to the required capacity. Overfilled tubes may clot and under filled tubes will give a false result
   iii. Line Draws: Coagulation studies are not to be drawn from A-lines unless ordered by a physician/AHP, except for NICU.
      1) The first 10 mL of blood must be discarded before blood is used to fill the coagulation tubes
         a) NICU: When utilizing venipuncture, do not discard any amount of specimen. Lines utilized for NICU Lab draws (in order of preference) should only be Umbilical Arterial Lines, Peripheral Arterial Lines, or Umbilical Venous lines.
      2) Phlebotomist/NICU RN must inform the Coagulation Department if a line draw must be done for a coagulation test.
      3) Must append a comment "line draw" to each test in the computer using FUNCTION: RE.
      4) Heel sticks and finger sticks are not allowed under any circumstances.
      5) Central Venous Access Devices: See Patient Care Service: Central Venous Access Devices, Adult Procedure.
   iv. Syringe draw: The last blood into a syringe will offer the best results for coagulation tests, so fill the blue top first.
      1) If only coagulation tests are ordered, draw an extra 1-2 mL to leave in the syringe.
   v. Butterfly draw: If the coagulation tube is the only tube to be drawn, a small red top tube should be drawn with at least 1 mL before filling the citrate tube (Blue Top).

19. Blood Cultures:

a. Use appropriate equipment and draw appropriate volume of blood based on patient's age/weight:
   i. Newborns (less than 4 kilograms [kg]):
      1) Collect 1 mL of blood in a Peds Plus bottle from one site only.
   ii. Children 2 years of age or less:
      1) Collect 5 mL of blood in a Peds Plus bottle from one site only.
   iii. Children 2-6 years of age or weighing 30 – 80 pounds (lbs):
      1) Use one aerobic and one anaerobic bottle and collect 5 mL of blood for each bottle
   iv. Adults and children weighing greater than 80 lbs:
      1) Use 2 sets of aerobic and anaerobic bottles, each bottle containing 8-10 mL of blood.
      2) Select a different venipuncture site for each blood culture.
         a) If poor access requires that blood for culture be drawn through a port in an IV or indwelling catheter, the second must be drawn from a peripheral site as cultures drawn through catheters can indicate catheter colonization.
         b) Do not draw blood from a vein into which an IV solution is infusing.

c) If venipuncture must be performed at the same site (usually due to bad veins), perform the second venipuncture at that site.

b. Once a site is selected, clean site as follows and avoid touching site after cleansing.
   i. For adults, children, and infants greater than 2 months old:
      1) Using Chloraprep, cleanse with gentle, repeated back and forth strokes for 30 seconds and allow to dry.
      2) For infants less than 2 months old and NICU infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU). Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for NICU infants.

c. Use a new needle with each venipuncture attempt.
   i. Do not palpate the skin after it is disinfected.

d. Pop the cap of the blood culture bottle and inoculate first the aerobic bottle and then the anaerobic bottle with the appropriate amount of blood.
   i. If the cap has been off the blood culture bottle for any amount of time, the rubber stopper on the bottle must be cleaned with an alcohol prep pad.
   ii. For direct inoculation into the bottles from the needle apparatus, mark the side of the bottle with the recommended draw.
      1) For Aerobic bottles, mark 3rd lines down from top of bottle.
      2) For anaerobic bottles, mark 2nd lines down from top of bottle.
   iii. If using a needle and syringe, use the volume markings on the syringe to note the volume.
      1) Hold the syringe plunger during transfer to avoid transfer of excess blood into bottles having significant vacuum.
   iv. There is no need to change the safety device between inoculations.

20. Bandage the site:
   a. Patients not on anticoagulants:
      i. Apply tape or an adhesive over the venipuncture site after checking that all bleeding has stopped. Ask the patient to leave the pressure dressing on for at least 30 minutes.
      ii. If the patient continues to bleed, apply pressure to the site with a gauze pad until the bleeding stops. Then apply clean folded gauze as a pressure dressing to the site. Ask the patient to leave on the bandage for at least one hour.
   b. Patients on anticoagulants:
      i. Apply pressure for 2 minutes and then check for bleeding.
      ii. Watch the venipuncture site for an additional 30-second interval until bleeding has stopped.
      iii. Place clean gauze pad on the site and tape to create a pressure bandage.
         1) Note: Patients on tPA will require additional pressure up to 20 minutes.

21. Disposal of Needle:
   a. Dispose of needles promptly to prevent their reuse or accidental injury. The vacutainer needle and vacutainer holder assembly are disposed of in the sharps container. The syringe and needle should all be discarded in the sharps container.
      i. Note: The vacutainer needle and holder will never be reused.
      ii. Never clip, bend, recap, unscrew or otherwise manipulate a needle by hand.

22. Labeling:
   a. Refer to Patient Care Services: Specimen Labeling Procedure.

23. Specimen Handling:
   a. Follow any special specimen handling requirements for the specimens drawn such as protecting from light, placing on ice, or keeping at body temperature.

24. Specimen Transport:
   a. When transporting from patient location to the Lab, place the specimens in a secondary container.
   b. When using the pneumatic tube system, place the specimens in a zip lock, leak proof bag with the requisition or labels in the side pocket or clipped to the outside of the bag.

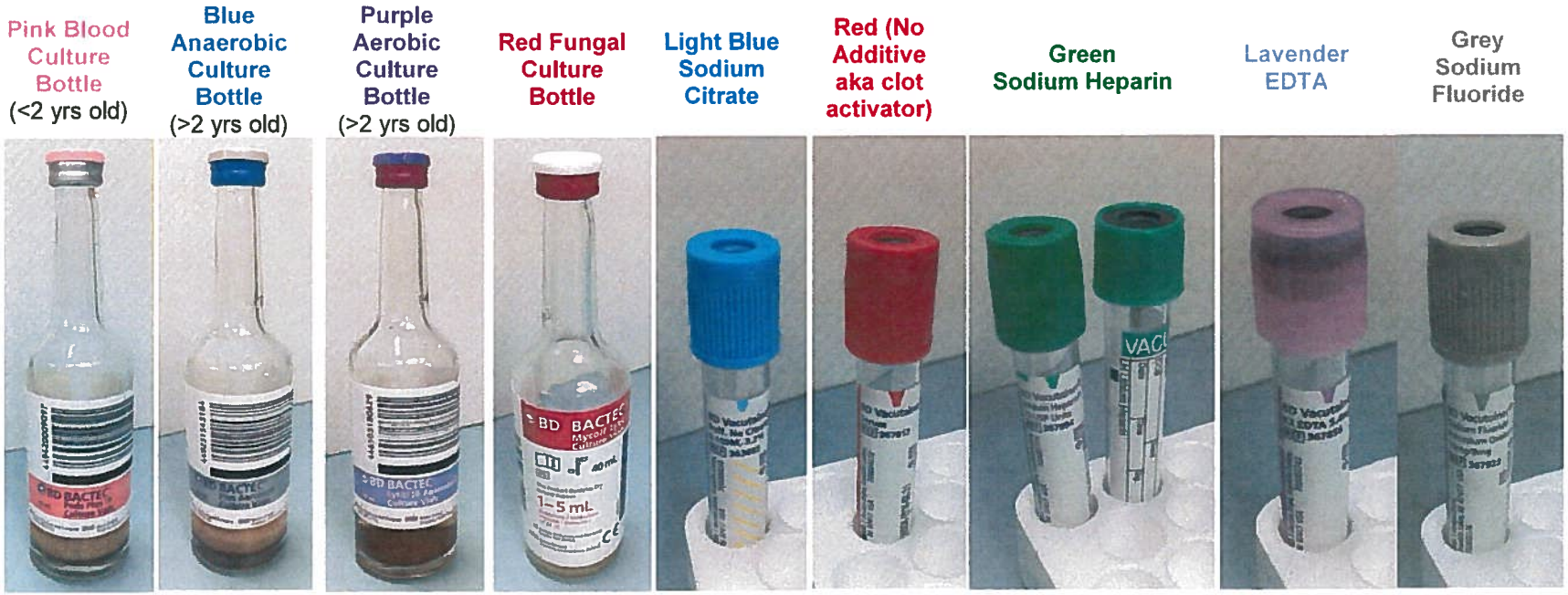
C. **RELATED DOCUMENT(S):**

1. Order of Draw
2. Patient Care Services: Central Venous Access Devices Procedure
3. Patient Care Services: Identification, Patients Policy
4. Patient Care Services: Specimen Labeling Procedure

D. **REFERENCE(S):**

1. CLSI (2010) Procedures for the Handling and Processing of Blood Specimen for Common Laboratory Tests; Approved Guideline – Fourth Edition. CLSI document GP44-A4. Wayne, PA: Clinical and Laboratory Standards Institute
2. CLSI (2010) Tubes and Additives for Venous and Capillary Blood Specimen Collection; Approved Standard – Sixth Edition. CLSI document GP39-A6. Wayne, PA: Clinical and Laboratory Standards Institute
3. CLSI (2017) Collection of Diagnostic Venous Blood Specimens. 7th ed. CLSI standard GP41. Wayne, PA: Clinical and Laboratory Standards Institute
4. CLSI (2017) Essential Elements of a Phlebotomy Training Program. 1st ed. CLSI document GP48. Wayne, PA: Clinical and Laboratory Standards Institute

Order of Draw



Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

SUBJECT: **Administration of Antipsychotic Medication**
POLICY NUMBER: **6340-725**

ISSUE DATE: **03/08**
REVISION DATE: **08/09, 03/13**

Department Approval:	**03/17**
Division of Psychiatry Approval:	**06/17**
Pharmacy and Therapeutics Approval:	**09/17**
Medical Executive Committee Approval:	**10/17**
Professional Affairs Committee Approval:	**11/17**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide guidelines for the safe use of antipsychotic medications within legal and regulatory guidelines to Voluntary and Involuntary patients on the inpatient behavioral health unit.

B. **POLICY:**
1. Any Food and Drug Administration (FDA) approved antipsychotic medication on the **Tri-City Healthcare District** (TC~~MC~~**HD)** formulary will be made available to patients, irrespective of their legal status, as clinically indicated and in accordance with accepted practice and principles of psychiatric practice when informed consent has been obtained or a patient has been determined to be incapable of making treatment decisions.

C. **DEFINITION(S):**
1. Antipsychotic medication: any drug customarily used for the treatment of symptoms of psychosis and other severe mental and emotional disorders ~~(Title 9, California Code of Regulations, Section 856)~~.
2. ~~A~~ Voluntary Patient: ~~is~~ an individual who meets inpatient psychiatric hospital severity of illness criteria, is capable of consent, and consents to inpatient hospital treatment. A Voluntary patient for the purposes of antipsychotic medication does not include voluntary minor patients, or Conservatees whose conservators have been given the right to require their Conservatees to receive treatment related specifically to remedying or preventing the recurrence of the Conservatees' being gravely disabled.
3. ~~An~~ Involuntary Patient: ~~is~~ an individual who has been hospitalized secondary to conditions described in California ~~Health and~~ Welfare **and Institutions** Code **(WIC)** sections 5150, 5250, 5260 or 5270.15.

D. **PROCEDURE:**
1. Voluntary Patients
   a. Every person admitted as a Voluntary patient has the right to refuse the administration of Antipsychotic medications.
   b. A Voluntary patient may be treated with antipsychotic medications only after being informed of the right to accept or refuse the medications and after consenting to the administration of the medication.

c. In order to make an informed decision the physician who prescribes the medication must provide the patient with sufficient information, in the patient's native language if possible. That information includes:
   i. The nature of the patient's condition
   ii. The reason for taking the medication including the likelihood of the patient's improving or not improving with the medication.
   iii. The reasonable alternative treatments available if any.
   iv. A statement that the patient may withdraw consent at any time.
   v. The type of medication, frequency of administration, dosage amount, method of administration and duration of taking the medication.
   vi. The probable side effects of the medication that are known to commonly occur.
   vii. The possible additional side effects that may occur in patients taking the medication longer than three months if applicable.

d. The physician will record the Voluntary patient's consent to take the medication on a written Consent to Receive Anti-psychotic Medications ~~(CAH form 4-7)~~ Form that complies with applicable state regulations.

e. If a Voluntary patient has been shown but does not wish to sign the written consent form it is sufficient for the physician to place the unsigned form in the patient's medical record together with a note that indicates that while the patient understands the nature and effect of the medication and consents to its administration, he/she does not desire to sign the written consent.

f. Medication may be administered in the absence of the patient's consent if it is impracticable to obtain consent, in emergency situations where there is a sudden marked change in the patient's condition which necessitates immediate action in order to preserve the life of or to prevent serious bodily harm to the patient and/or others.

g. A Voluntary patient may withdraw consent to the administration of the medication at any time by stating such intention to any member of the treatment team.

h. The refusal of the patient to consent to the administration of antipsychotic medication does not, in itself, constitute sufficient grounds for initiating an involuntary hold.

2. Involuntary patients

a. Involuntary patients must not be given antipsychotic medication without their informed consent unless they do not refuse the medication following disclosure of the pertinent informed consent information (a-g above), there is an emergency, or a court has determined that the patient is incompetent to make an informed decision concerning medication.
   i. Antipsychotic medication may be administered to an involuntary patient if the patient has been given the pertinent information about the medication and does not refuse the medication even if the patient does not expressly agree to take the medication ~~(Welfare and Institutions Code Section 5332 (a))~~. If the patient does not refuse to take the medication but refuses to sign the consent form after having received the pertinent information about the medication, a note to this effect should be written in the medical record and a copy of the consent form should be placed in the medical record as well.

b. An emergency is defined, for this purpose, as a situation in which action to impose treatment over the person's objection is immediately necessary for the preservation of life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first gain consent. The emergency exemption justifies administration of the medication only so long as the emergency exists. Once the condition is stabilized, the patient's informed consent is required. In addition, the medication administered in emergencies must be only that required to treat the emergency condition and must be provided in the manner least restrictive to the personal liberty of the patient.

c. Antipsychotic medications may be administered over the patient's objection in non-emergency situations only if the treatment staff have determined that treatment

alternatives to involuntary medication are unlikely to meet the needs of the patient and a judicial determination of incapacity to refuse medications has been made.

d. These guidelines apply to patients who are detained pursuant to ~~Welfare and Institutions Code~~**WIC** Sections 5150 (72 hour holds), 5250 (14 day holds), 5260 (additional 14 day hold for persons imminently suicidal), or 5270.15 (additional 30 day hold for personals gravely disabled~~.~~).

e. As with consent for medical treatment, if an Involuntary patient gives informed consent for antipsychotic medication, that person may at any time withdraw that consent by informing any member of the treatment team of that decision.

f. Hearings to determine the patient's capacity to refuse medication

i. The purpose of the hearing is for a hearing officer to determine whether the patient has the capacity to make an informed decision regarding the proposed treatment.

ii. To initiate a hearing the director of the program or his/her designee must provide a copy of the notice of the filing of the petition for the hearing along with a copy of the petition to the patient and patient's advocate or counsel, inform the patient of his or her legal right to a capacity hearing, and inform the patient of his or her right to the assistance of the patients' right advocate or an attorney to prepare for the hearing and to answer any questions or concerns.

iii. A patients' right advocate will meet with the patient as soon after the filing of the petition is practicable.

iv. The hearing must be held within 24 hours of the filing of the petition whenever possible. If any party needs additional preparation time it may be postponed for 24 hours but in no case may the hearing be delayed beyond 72 hours of the filing of the petition.

v. Hearings are held on the behavioral health unit and are conducted by a court-appointed hearing officer.

vi. The patient will be given verbal notification of the determination of the hearing officer at the conclusion of the hearing and as soon thereafter as is practicable the patient and the hospital will be given written notification of the determination.

vii. The patient may appeal the determination but if he or she decides to do so, antipsychotic medication may be administered pending the appeal.

viii. The judicial determination of a patient's incapacity to refuse antipsychotic medication remains in effect only for the duration of the detention period prescribed by the particular hold in effect.

E. FORM(S):

1. Consent to Receive Anti-psychotic Medications

~~ix.~~2. Consent to Receive Psychotropic Medication

F. REFERENCE(S):

1. Additional Intensive Treatment of Suicidal Persons, Cal. WIC §§5260 and 5270.15

2. Certification for Intensive Treatment, Cal. WIC § 5250

3. Detention of Mentally Disordered Persons for Evaluation and Treatment, Cal. WIC §5150

4. Legal and Civil Rights of Persons Involuntary Detained, CAL. WIC § 5332

5. Title 9, California Code of Regulations, Section 856

Consent to Receive Anti-psychotic Medications

○ ○ ○ ○ ○

The purpose of this is to explain the anti-psychotic medications my psychiatrist wishes to include in my treatment. My physician has advised me that anti-psychotic medications are necessary for my treatment and is requesting that I consent to receive these medications:

Medication(s)

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

A. My physician discussed the nature of my medical condition with me.

B. My physician has given me the reason for taking such medications including the likelihood of improving or not improving without such medications and has informed me that **my consent can be withdrawn at any time by telling either my physician or member of my treatment team.**

C. My physician has told me of any reasonable alternatives treatments available, if there are any.

D. My physician has informed me of the type of medications he/she will prescribed for me; how often, in what amount, for how long and by what route (by mouth or injection).

E. My physician has told me of common side effects that may occur when taking these medications, and especially those that I may have because of factors personal to me.

F. My physician has discussed with me any possible side effects, which may occur to patients taking certain categories of medications. Such side effects may include persistent involuntary movement of the face of mouth and might at times, include similar movements of the hands and feet, and that these symptoms are potentially irreversible and may appear after the medications have been discontinued. These medications may also cause restlessness, increased muscle tone, elevated blood sugar, lipids, and weight gain.

G. The general side effect profile(s) of the above medications have been reviewed with me and could include some specifically from the list below. This is not a complete list of all the possible side effects. I consent to the use of the prescribed medication(s). I understand that I can withdraw this consent at any time by informing my physician.

Cardiac conduction changes	Elevated cholesterol/triglycerides	Motor changes/EPS
Changes in blood count	Glaucoma	Nausea/vomiting
Confusion	Headaches	Renal impairment
Diabetes/elevated glucose	Hypothyroidism	Sedation/stimulation
Diarrhea/constipation	Insomnia	Seizures
Elevated blood pressure	Liver inflammation	Weight gain/loss

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6340-1060
(Rev. 3/17)

CONSENT TO RECEIVE ANTI-PSYCHOTIC MEDICATIONS
Page 1 of 2

Affix Patient Label

Board Approved (Date)

Authorization
White – Chart Yellow –Patient

While I have a right as a patient to refuse to accept these medications, my physician may, in an emergency, order that I be given these medications without my consent. Such an emergency is defined when there is a sudden marked change in my condition leading to a need to protect my life or prevent serious bodily harm to me or to others.

I HAVE RECEIVED WRITTEN AND ORAL INFORMATION REGARDING SPECIFIC MEDICATIONS I AM TAKING.

I. Having been advised and informed of all of the above by my physician, I consent to receiving these medications as my physician prescribed them.

Name: Patient Representative	Signature: Patient/Representative	____/____/____ Date	_____:_____ AM/PM Time
Witness – TCHD Representative (print name)	**Signature** • *Firma*	**Date** • *Fecha*	**Time** • *Hora*

II. Patient has been advised of, and understands, ALL the above information and consents to receiving these medications as prescribed. However, the patient chooses not to sign this consent form.

Witness – TCHD Representative (print name)	**Signature** • *Firma*	**Date** • *Fecha*	**Time** • *Hora*

III. Patient willing to take medication, however, patients cognitive functioning limits the ability to understand and sign.

Witness – TCHD Representative (print name)	**Signature** • *Firma*	**Date** • *Fecha*	**Time** • *Hora*

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI ☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with: _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	____/____/____ Date	_____:_____ AM/PM Time

☐ Patient refused TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

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CONSENT TO RECEIVE ANTI-PSYCHOTIC MEDICATIONS
Page 2 of 2

Affix Patient Label

Board Approved (Date)

Authorization
White – Chart Yellow –Patient

Consent to Receive Psychotropic Medication

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

INSTRUCTIONS TO PATIENT: The form describes information your physician will provide to you regarding your treatment with Antipsychotic, Psychotropic or Neuroleptic medications. Please read the form thoroughly before you sign it and if you have any questions, ask your physician. **This is a two-sided form.**

My psychiatrist has advised me that psychotropic medications are necessary for my treatment and has discussed the following information with me:

Category of Medication and Name of Medication:

❑ Anti-Depressant _____ ❑ Mood-Stabilizer _____
❑ Anti-Anxiety _____ ❑ Anti-Psychotic _____
❑ Hypnotic _____ ❑ Other _____

1. My physician discussed the nature of my medical condition with me.
2. My physician has given me the reason for taking such medications including the likelihood of improving or not improving without such medications and has informed me that my consent can be withdrawn at any time by telling either my physician or member of my treatment team.
3. My physician has told me of any reasonable alternative treatments available, if there are any.
4. My physician has informed me of the type of medications he/she will prescribed for me; how often, in what amount, for how long and by what route (by mouth or injection).
5. My physician has told me of common side effects that may occur when taking these medications, and especially those that I may have because of factors personal to me.
6. My physician has discussed with me any possible side effects, which may occur to patients taking certain categories of medications. Such side effects may include persistent involuntary movement of the face of mouth and might at times, include similar movements of the hands and feet, and that these symptoms are potentially irreversible and may appear after the medications have been discontinued. These medications may also cause restlessness, increased muscle tone, elevated blood sugar, lipids, and weight gain.
7. The general side effect profile(s) of the above medications have been reviewed with me and could include some specifically from the list below. This is not a complete list of all the possible side effects. I consent to the use of the prescribed medication (s). I understand that I can withdraw this consent at any time by informing my physician.

Cardiac conduction changes	Elevated cholesterol/triglycerides	Motor changes/EPS
Changes in blood count	Glaucoma	Nausea/vomiting
Confusion	Headaches	Renal impairment
Diabetes/elevated glucose	Hypothyroidism	Sedation/stimulation
Diarrhea/constipation	Insomnia	Seizures
Elevated blood pressure	Liver inflammation	Stroke
		Weight gain/loss

While I have a right as a patient to refuse to accept these medications, my physician may, in an emergency, order that I be given these medications without my consent. Such an emergency is defined when there is a sudden marked change in my condition leading to a need to protect my life or prevent serious bodily harm to me or to others.

Affix Patient Label

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CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION

Page 1 of 2

6340-1001
(Rev 11/00)

White - Medication Records Yellow - MAR

Punch Other

Fold

I. Having been advised and informed of all of the above by my physician, I consent to receiving these medications as my physician prescribes them.

PATIENT'S SIGNATURE	DATE/TIME	PHYSICIAN'S SIGNATURE	DATE/TIME

II. I ask that my physician not explain all of the above to me because of the distress this causes me, and I consent to receiving these medications as my physician prescribes them.

PATIENT'S SIGNATURE	DATE/TIME	PHYSICIAN'S SIGNATURE	DATE/TIME

WITNESS	DATE/TIME

III. Patient has been advised of, and understands, ALL the above information and consents to receiving these medications as I prescribe them. However, the patient chooses not to sign this consent form.

PHYSICIAN'S SIGNATURE	DATE/TIME	WITNESS	DATE/TIME

IV. Patient takes medication willingly, however, patients cognitive functioning severely limits understanding.

PHYSICIAN'S SIGNATURE	DATE/TIME	WITNESS	DATE/TIME

Affix Patient Label

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CONSENT TO RECEIVE
PSYCHOTROPIC MEDICATION

Page 2 of 2

6340-1001
(Rev. 11/08)

White - Medical Records Yellow - MAR

Tri-City Medical Center
Oceanside, California

ENGINEERING
EQUIPMENT

SUBJECT: Utility Management Plan
POLICY NUMBER: 4003

ISSUE DATE: 09/94
REVIEW DATE(S): 08/15
REVISION DATE(S): 02/97, 05/00, 05/03, 06/06, 05/09, 06/12, 06/15, 10/15, 01/17

Department Approval:	~~10/16,~~ 07/17
Environmental Health and Safety Committee Approval:	~~10/16,~~ 08/17
Professional Affairs Committee Approval:	~~01/17~~11/17
Board of Directors Approval:	01/17

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

1. Design, operate and maintain utility systems serving the buildings that house the healthcare services of TCHD to provide a safe, comfortable, appropriate environment that supports patient care and business operations.
2. Perform recommended maintenance to maximize system service life and reliability.

3. Manage the Utility Systems Management program to assure compliance with The Joint Commission requirements.

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

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

utility system equipment maintained by the Engineering and Maintenance staff and equipment maintained by vendors.

4. ~~**UM.EC.02.05.01 EP3 –**~~ **Maintenance Strategies**
   a. The Director of Engineering **or Designee** evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The Director of Engineering **or Designee** uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.
5. ~~**UM.EC.02.05.01 EP4 –**~~ **Inspection, Testing, and Maintenance Intervals**
   a. The Director of Engineering **or Designee** uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
   b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
   c. The Director of Engineering **or Designee** is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.
6. ~~**UM.EC.02.05.01 EP5 –**~~ **Management of Water Systems**
   a. The Director of Engineering **or Designee** and ~~the~~ Infection **Control** ~~Preventionist~~ are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
   b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
   c. The Director of Engineering **or Designee** and ~~the~~ Infection **Control** ~~Preventionist~~ are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
   d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.
7. ~~**UM.EC.02.05.01 EP6 –**~~ **Management of Ventilation Systems**
   a. The Director of Engineering **or Designee** and ~~the~~ Infection ~~Preventionist~~ **Control** are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
   b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant ~~Maintenance.~~ **Operations.**
   c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.
   d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Engineering **or Designee** and Infection **Control** ~~Preventionist~~ develops, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.

8. ~~**UM.EC.02.05.01 EP7 –**~~**Mapping of Utility Systems**
   a. The Director of Engineering **or Designee** is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built and record drawings, one line drawing's, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Engineering Shared Drive.
9. ~~**UM.EC.02.05.01 EP8 –**~~**Labeling of Controls for System Shutdown and Recovery**
   a. The Director of Engineering **or Designee** is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
   b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.
10. ~~**UM.EC.02.05.01 EP9 – 13 –**~~**Emergency Procedures**
    a. The Director of Engineering **or Designee** and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
    b. The Director of Engineering **or Designee** and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
    c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
    d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job related orientation process. All utility systems emergency procedures are reviewed annually.
11. ~~**UM.EC.02.05.03 EP1 – 6 and EC.02.05.07 EP1 - 10 –**~~**Inspection, Testing, and Maintenance of Emergency Power Systems**
    a. The Director of Engineering **or Designee** is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
    b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
    c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
    d. The Director of Engineering **or Designee** is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected

load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.

e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.

g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process specified by NFPA 99 and NFPA 110.

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

12. ~~**UM.EC.02.05.05 EP1 -**~~ **Utility Systems Inventory and Initial Testing**

a. The Director of Engineering **or Designee** establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.

b. The Director of Engineering **or Designee** is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.

13. ~~**UM.EC.02.05.05 EP3 -**~~ **Testing of Life Support Equipment**

a. The Director of Engineering **or Designee** assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering **or Designee** will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

14. ~~**UM.EC.02.05.05 EP4 -**~~ **Testing of Infection Control Support Equipment**

a. The Director of Engineering **or Designee** assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Engineering **or Designee** will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

15. ~~**UM.EC.02.05.05 EP5 -**~~ **Testing of Non-Life Support Equipment**

a. The Director of Engineering **or Designee** assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.

16. ~~**UM.EC.02.05.09 EP1 -**~~ **Medical Gas System Testing**

a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection is done in accordance with the requirements of the current edition of NFPA 99.

17. ~~**UM.EC.02.05.09 EP2 -**~~ **Modifying / Repairing Medical Gas Systems**
    a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Engineering **or Designee** coordinates certification of the system by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Engineering **or Designee** maintains a permanent record of all certification testing.
18. ~~**UM.EC.02.05.09 EP3 -**~~ **Labeling & Accessibility of Medical Gas Controls**
    a. The Director of Engineering **or Designee** is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
    ~~b.~~ In addition, the Director of Engineering **or Designee** is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled ~~environmental tours. Deficiencies are reported to the appropriate manager for resolution.~~

~~19. **EC.04.01.01 EP1 – 11 – The hospital monitors conditions in the environment**~~

~~a. The Sr. Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety/EOC works with the Sr. Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported.~~

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

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

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

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

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

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

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

~~b. The annual evaluation examines the management plans to determine if they accurately~~

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

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

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

21. **EC.04.01.03 EP1 – 3 - Analysis and actions regarding identified environmental issues**

a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

22. **EC.04.01.05 EP1 – 3 – Improving the Environment**

a. When the leadership of the hospital, performance improvement, or patient safety concurs with the EHSC recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

23. **LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3 – Orientation and Ongoing Education and Training**

a. Orientation and training addressing all subjects of the environment of care is provided to each employee, volunteer, contract staff and to each new medical staff member at the time of their employment or appointment.

b. In addition, all current employees, as well as volunteers, physicians, and students participate in an annual update of the orientation program as deemed appropriate. The update addresses changes the procedures and controls, laws and regulations, and the state of the art of environmental safety.

c. The Human Resources Department with assistance from the Education Department coordinates the general orientation program. New staff members are required to attend the first general orientation program after their date of employment. The Human Resources Department maintains attendance records for each new staff member

~~completing the general orientation program.~~

~~d. New staff members are also required to participate in orientation to the department where they are assigned to work.~~

~~e. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.~~

~~f. The Director of Safety/EOC collaborates with the Environment of Care managers, department heads, the Director of Performance Improvement, the Director of Infection Control, and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care Program and revised as necessary.~~

~~g. The Director of Safety/EOC gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work.~~

~~h. In addition the Director of Safety/EOC evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.~~

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

F. **AFFECTED PERSONNEL/AREAS:**

1. Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors; Contract Services and Staff.~~;~~

G. **REFERENCE(S):**

1. The Joint Commission **(2017).** ***Hospital Accreditation Standards.*** **Illinois: Joint Commission Resources.**

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Life Safety Management

SUBJECT: **Life Safety Management Plan**

ISSUE DATE: 11/87
REVIEW DATE(S): 03/00, 04/06, 04/09
REVISION DATE(S): 04/13, 05/12, 06/15

Department Approval:	~~06/16,~~ 07/17
Environmental Health and Safety Committee Approval:	~~08/16,~~ 08/17
Professional Affairs Committee Approval:	~~01/17~~11/17
Board of Directors Approval:	01/17

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

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

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

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

Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Engineer ~~(Facilities Manager)~~ **or Designee** assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer ~~(Facilities Manager)~~ **or Designee** permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services of **TCHD**~~Tri-City Healthcare District~~.

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

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

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

b. The department and area specific fire response plans include information about:
   i. The roles of all employees, medical staff, volunteers, contract staff and students near the point of fire origin.
   ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.
      1) Note: **TCHD**~~Tri-City Healthcare District~~ believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.
   iii. Operation of the fire alarm system.
   iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

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

responsible for preparing a letter to the appropriate Joint Commission staff requesting an extension of the timeframe or a change of the method of correction.

9. Management of Fire Safety Risks (LS.01.02.01 EP1 – 14)
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
   b. The Director of Engineering ~~(Facilities Manager)~~ **or Designee** and Safety Officer are responsible for implementation of the ILSMP. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
   c. The Director of Engineering ~~(Facilities Manager)~~ **or Designee** and Safety Officer are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Officer and/or the Director of Engineering ~~(Facilities Manager)~~ **or Designee** take appropriate action to resolve the deficiencies.
   d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented. The documentation is presented to the Environmental Health & Safety Committee as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.
10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EC.04.01.01 EP11)
   a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Officer works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
   b. Incident reports are completed by a witness or the staff member to whom a patient or visitor incident is reported. The completed reports are forwarded to the Director of Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
   c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the Environmental Health **and**~~&~~ Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
   d. The Safety Officer coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of **TCHD**~~Tri-City Healthcare District~~.
   e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
   f. The Environmental Health ~~&~~**and** Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

g. The Safety Officer prepares a quarterly report to the leadership of **TCHD**~~Tri-City Healthcare District~~. The quarterly report summarizes key issues reported to the Committees and the recommendations of them.

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

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

a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.

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

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

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

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – 3)

a. The Environmental Health **&and** Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

13. Improving the Environment (EC.04.01.05 EP1 – 3)

a. When the leadership of the hospital, quality improvement, or patient safety concurs with Environmental Health **&and** Safety Committee recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health **&and** Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

b. The Environmental Health **&and** Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance

improvement, and patient safety leadership.

14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3)
    a. Orientation and training addressing subjects of the environment of care is provided to each employee, volunteer, and to each new medical staff member at the time of their employment or appointment.
    b. In addition, all current employees complete an annual review of life safety via a CBL module and documented in the Netlearning system.
    c. The Human Resources Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.
    d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations.
    e. The Safety Officer collaborates with the Environment of Care managers, department heads, the Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
    f. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job related risks are to be managed or eliminated as part of daily work. In addition the Safety Officer evaluates the degree to which staff members understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health **&and** Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **GOALS-/OBJECTIVES FOR ~~FY17~~ 2018**

1. ~~Complete an assessment of TCHD compliance to the new 2012 Life Safety Codes and Health Care Facilities Codes and have action plans for any areas found to not meet the new standards.~~ **Continue working with staff to assure they have a good working knowledge of the expectations of their roles during a Life Safety emergency situation.**
2. ~~Complete a thorough hospital-wide review of all fire alarm and suppression systems by Red Hawk.~~ **Insure that RedHawk Life Safety continues to inspect fire systems in accordance with all Regulatory Agencies and corrects deficiencies within mandated time lines.**
3. ~~Work with staff to create a better working knowledge and adaption of NFPA 2012 standards to existing policies and procedures.~~ **Continue working with department staff, specifically OR with fire extinguisher trainings and hands on techniques when dealing with an emergency fire situation in their work area.**
4. Continue to work with staff and contractors in regards to both pre and post activities during construction phases that are necessary to maintain the safety of staff, patients and visitors to the facility.

G. **REFERENCE(S):**

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

3. The 2012 Edition NFPA 99 Health Care Facilities Code

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Safety Management

SUBJECT: **Safety Plan**

ISSUE DATE: 11/87
REVIEW DATE(S): 06/08, 06/12
REVISION DATE(S): 05/96, 06/97, 07/00, 03/11, 06/15, 07/17

Department Approval:	~~05/15,~~ 07/17
Environmental Health and Safety Committee Approval:	~~06/15,~~ 08/17
Professional Affairs Committee Approval:	~~01/17~~11/17
Board of Directors Approval:	01/17

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

1. The identification of specific risks faced by patients and employees, and others is essential for designing safe work areas and work practices.
2. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate staff to effectively use work environments and safe work practices to minimize the potential for adverse impact on them, patients, and other individuals coming into the environment.
3. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.

C. **OBJECTIVES**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and employees to evaluate the potential adverse impact on all persons coming to the facilities of ~~Tri-City Healthcare District~~**TCHD**.
2. Perform additional risk assessments when changes involving these issues occur.
3. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
4. Make changes in the procedures and controls to address identified root causes of incidents.
5. Conduct environmental (~~"~~EOC~~"~~) rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluates the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
6. Present quarterly reports of EC management activities to the environmental Health & Safety Committee. The reports from each EC area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified EC issues. The Safety Officer coordinates the documentation and presentation of this information.
7. Assure that all departments have current organization-wide and department specific procedures and controls designed to manage identified risks.
8. Review the risks and related procedures and controls at least once every three years to assure that the EC programs are current.
9. Assign qualified individuals to manage the EC programs and to respond to immediate threats to life and health.
10. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the environmental safety program.
11. Design and present environmental safety education and training to all new and current employees, volunteers, members of the medical staff and others as appropriate.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Safety (Safety Officer), Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program. They collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program. They also collaborate with the Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
2. The Environmental Safety Leadership Team coordinates the development of reports to the Environmental Health **&and** Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
3. The Environmental Health **&and** Safety Committee monitors and evaluates the processes used to manage the environment of care. Members of the Environmental Health **&and** Safety Committee are appointed by the Committee Chair. The Environmental Health **&and** Safety Committee meets a minimum of four (4) times per year. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes and other issues are presented as appropriate. The Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.
4. The Committee assigns individuals or groups responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.

5. Membership of the Committee includes representation from Nursing Administration, Facilities Management, Risk Management, Quality Improvement, Human Resources, Senior Administration, Bio-Medical Services, Education, Medical Staff, Physician representation, Infection Control and others as deemed appropriate.
6. The Board of Directors of ~~Tri-City Healthcare District~~**TCHD** receives regular reports of the activities of the environmental safety program from the Environmental Health **&and** Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer. The Board collaborates with the **Chief Executive Officer (**CEO**)** and other senior leadership to assure budget and staffing resources are available to support the environmental safety program.
7. The CEO or designee of ~~Tri-City Healthcare District~~**TCHD** receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.
8. The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.
9. The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.
10. Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.
11. Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:

1. Appointment of Environmental Safety Leadership (EC.01.01.01 EP1)
   a. The CEO appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The ~~Environmental Safety Leadership Team (~~ESLT~~)~~ includes the ~~Director of Safety (~~Safety Officer~~)~~, Director of Risk Management/Quality Improvement, Director of Regulatory Compliance and Infection Control, and the Director of Engineering.
   b. The ESLT coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.
   c. The ESLT maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of ~~Tri-City Healthcare District~~**TCHD**.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for ~~Tri-City Healthcare District~~**TCHD** that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander

is appointed at the time any emergency response is implemented.

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

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

3. Environmental Safety Management Plan (EC.01.01.01 EP3)
   a. The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of ~~Tri-City Healthcare District~~**TCHD**.
4. The hospital identifies safety risks associated with the environment of care (EC.01.02.01 EP1)
   a. The ESLT of ~~Tri-City Healthcare District~~**TCHD** performs proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as environmental "EOC" rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts, CDPH All Facilities Letters (AFLs), Cal/OSHA standards, and FDA product recall notices.
   b. The ESLT coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.
5. The hospital takes action to minimize or eliminate identified safety risks in the physical **environment (EC.02.01.01 EP3)**
   ~~environment (EC.02.01.01 EP3)~~
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 & EP2)
   a. The Safety Officer follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The Safety Officer assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.
   d. The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.

7. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   a. The Director of Engineering (Facilities Management) is responsible for managing the appearance and safety of the hospital grounds. In addition, the Director of Engineering is responsible for assuring that the equipment used to maintain the grounds is in proper operating condition and that grounds staff is trained to operate and maintain the equipment.
   b. The Director of Engineering (Facilities Management) is responsible for scheduling the work required to maintain the appearance and safety of hospital grounds. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.
8. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   a. The Director of Safety and the Director of Materials Management coordinate a product safety recall system. ~~Tri-City Healthcare District~~**TCHD** utilizes the NRAC E-Class system that is designed to quickly assess safety recall notices; to respond to those that affect ~~Tri-City Healthcare District~~**TCHD**; and to assure all active safety recalls are completed in a timely manner.
   b. A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from ~~Tri-City Healthcare District~~**TCHD** is presented to the Environmental Health & Safety Committee by the Director of Safety.
9. The hospital prohibits smoking (EC.02.01.03 EP1 & EP2)
   a. ~~Tri-City Healthcare District~~**TCHD** has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (ie: cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor producing devices) in any hospital building or grounds by all, including staff, visitors and patients.
   b. ~~Tri-City Healthcare District~~**TCHD** has identified alternatives to tobacco products that are offered to all. ~~Tri-City Healthcare District~~**TCHD** has developed tobacco replacement product resources to assist staff and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost.
10. The hospital takes action to maintain compliance with its smoking policy (EC.02.01.03 EP6)
   a. The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.
11. The hospital monitors conditions in the environment (EC.04.01.01 EP1 - EP11)
   a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Director of Safety (Safety Officer) works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
   b. Incident reports are completed by a staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
   c. In addition, the Director of Risk Management and the Safety Officer collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health **&and** Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
   d. The Safety Officer coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of ~~Tri-City Healthcare District~~**TCHD**.
   e. The Environmental Health **&and** Safety Committee and the Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for

setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

f. The Chairperson of the Environmental Health & Safety Committee prepares quarterly reports to the leadership of ~~Tri-City Healthcare District~~**TCHD**. The quarterly reports summarize key issues reported to the EHSC **&and** PSC committees with their recommendations. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out. ~~Semi-~~Annual reports are provided to the Board of Directors related to EC**, or more often if warranted**.

12. Environmental tours are conducted ~~every six months~~**annually** in patient care areas (EC.04.01.01 EP12)
    a. Environmental "EOC" rounds at ~~Tri-City Healthcare District~~**TCHD** are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every ~~six~~ **twelve** months. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
    c. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
13. Environmental tours are conducted annually in non-patient care areas (EC.04.01.01 EP13)
    a. Environmental "EOC "rounds at ~~Tri-City Healthcare District~~**TCHD** are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).
    b. Additional environmental "EOC" tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
14. The hospital uses its tours to identify deficiencies, hazards, and unsafe practices (EC.04.01.01 EP14)
    a. The ESLT manages a process of environmental "EOC" rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.
    b. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.
15. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Director of Safety (Safety Officer) coordinates the annual evaluation of the management plans associated with the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care program to determine if

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

c. In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement.

d. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer.

e. The results of the annual evaluation are presented to the Environmental Health **&and** Safety Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

f. The annual evaluation is distributed to the ~~Chief Executive Officer~~**CEO**, Board of Directors, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

16. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)

a. The Environmental Health **&and** Safety Committee receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

b. Each time a need for improvement is identified the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the quality improvement program, and the patient safety program.

17. Improving the Environment (EC.04.01.05 EP1 – EP 3)

a. When the leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the Environmental Health **&and** Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health **&and** Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

b. The Environmental Health **&and** Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

18. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 & EC.03.01.01 EP1 – EP3)

a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.

b. In addition, annual EOC training is provided and documented via NetLearning.

c. The Human Resources Department with participation from the Education Department coordinates the general New Employee Orientation (NEO) program. New staff members are required to attend the NEO program within 30 days of their date of employment. The Human Resources Department with participation from the Education Department

maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the EC managers, department leaders, the Director of Risk Management/Quality, Director of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

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

F. **GOALS/OBJECTIVES FOR ~~FY17~~FY18:**

1. ~~Create a Workplace Violence Prevention (WPV) Committee to address the new 2016/2017 Cal/OSHA WPV prevention standards. Measurement of success will be the creation of the committee, regularly attended meetings and a plan in place to meet the requirements within the allotted timeframe provided by Cal/OSHA~~**Meet all of the new Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulation requirements by April 1, 2018**.
2. Complete WPV risk assessments for all departments, services throughout the medical center and off-site locations.

G. **RELATED DOCUMENTS:**

1. Administrative Policy: Smoke Free Environment #205

H. **REFERENCES:**

1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)
~~1.~~2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Security Management

SUBJECT: **Security Management Plan**

ISSUE DATE: **01/97**
REVIEW DATE(S): **01/99**
REVISION DATE(S): **07/00, 04/03, 12/05, 12/11, 06/15, 07/17**

Department Approval:	~~06/16,~~ **07/17**
Environmental Health and Safety Committee Approval:	~~09/16,~~ **08/17**
Professional Affairs Committee Approval:	~~01/17~~**11/17**
Board of Directors Approval:	**01/17**

A. **EXECUTIVE SUMMARY:**

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

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

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

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

6. Individual staff members are responsible for learning and following job and task specific procedures for secure operations.

E. **ELEMENTS OF THE SECURITY PLAN:**

1. Appointment of Security Leadership (SEC.EC.01.01.01 EP1)
   a. The CEO of ~~Tri-City Healthcare District~~**TCHD** appoints the Safety Officer, and selects a qualified individual capable of overseeing the development, implementation and monitoring of the security program. The Safety Officer's job is defined by a job description. The CEO or a designee evaluates the competence of the Safety Officer annually.
   b. The ~~Security Manager~~**Director of Security** coordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate. The ~~Security Manager~~**Director of Security**'s job is defined by a job description. The CEO or a designee evaluates the competence of the ~~Security Manager~~**Director of Security** annually.
   c. The ~~Security Manager~~**Director of Security** maintains a current knowledge of laws, regulations, and standards of security. The ~~Security Manager~~**Director of Security** also continually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of ~~Tri-City Healthcare District~~**TCHD**.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified (EC.01.01.01 EP2)
   a. The Emergency Management program includes specific response plans for ~~Tri-City Healthcare District~~**TCHD** that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the HICS (Hospital Incident Command System) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
   c. The CEO has appointed the Safety Officer, the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.
3. Management Plan for a Secure Environment (SEC.EC.01.01.01 EP4)
   a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of ~~Tri-City Healthcare District~~**TCHD** experience an adverse security event.
4. Proactive Risk Assessment (SEC. EC.02.01.01 EP1)
   a. The ~~Security Manager~~**Director of Security** of ~~Tri-City Healthcare District~~**TCHD** coordinates proactive risk assessments to identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others.
   b. The ~~Security Manager~~**Director of Security** works with department directors, managers, the Patient Safety Officer, Risk Management and others as appropriate.
   c. The Security Department will be responsible for enacting proactive security measures as

follows:

i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/accidents.
ii. Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspections of all sensitive areas throughout the Medical Center.
iii. Ensuing that all employees and physicians properly display their photographic identification badges at all times.
iv. Submitting reports to the Director of Engineering pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.
v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and Women's Center. Security will also ensure a location for long-term vehicle parking.
vi. Monitoring the Security Department CCTV.
vii. Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment (EC.02.01.01 EP3)
   a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.
   b. **In response to the 2016 Cal/OSHA, Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations, ~~Tri-City Healthcare District~~TCHD has created new environmental risk assessment tools and general employee education programs.**
   ~~a.~~**c.** ~~**Tri-City Healthcare District**~~**TCHD**~~Tri-City Hospital District~~ has elected to implement the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of staff **working in high-risk areas** in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:
      i. General safety measures.
      ii. Personal safety measures.
      iii. The assault cycle.
      iv. Aggression and violence predicting factors.
      v. Characteristics of aggressive and violent patients and victims.
      vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
      vii. Strategies to avoid physical harm.
      viii. Restraining techniques.
      ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).
   d. A condensed version of the NVCI program will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.
6. Development and Management of Policies and Procedures (LD.04.01.07 EP1 ~~&~~**and** EP2)
   a. The ~~Security Manager~~**Director of Security** follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. The ~~Security Manager~~**Director of Security** assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and

controls are maintained by department directors. The directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job related policies, procedures and controls. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is responsible for implementing the policies, procedures and controls related to her/his work processes.

c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The ~~Security Manager~~**Director of Security** coordinates the reviews of procedures with department leaders and other appropriate staff.

7. Identification of Patients, Staff, and Others Entering the Facility (SEC.EC.02.01.01 EP7)
   a. The identification of staff is an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place at ~~Tri-City Healthcare District~~**TCHD** include photographic ID badges for all staff, volunteers, students, contracted staff and members of the medical staff, password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of staff.
   c. The identification of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering ~~Tri-City Healthcare District~~**TCHD** is managed by the Security and Materials Management Departments. The ~~Security Manager~~**Director of Security** in collaboration with the CEO or designee and other appropriate staff provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The ~~Security Manager~~**Director of Security** takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to ~~Tri-City Healthcare District~~**TCHD**.
8. Identification and Management of Security Sensitive Areas (SEC.EC.02.01.01 EP8)
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department.
      ii. Behavioral Health and Crisis Stabilization Units.
      iii. Maternal Child Health.
      iv. Neonatal Intensive Care Unit.
      v. Pharmacy Department.
      vi. Human Resources Department.
      vii. Adult Critical Care Unit.
      viii. Information Technology.
      ix. Administration.
      x. 3rd Floor Center Tower Progressive Care Unit.
      xi. Medical Records Office and Storage areas.
      xii. Nuclear Medicine Hot Lab.
   b. Staff in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.
   c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:
      i. Emergency Department:
         1) Electronic access control.

2) Panic buttons.
3) Closed Circuit Television (CCTV) cameras.
4) Security Officer Station – Posted 24 hours per day.

ii. Behavioral Health Units:
1) Electronic access control.
~~1)~~**2) Panic buttons.**
~~2)~~**3)** CCTV.

iii. Maternal Child Health Units:
1) Electronic access control.
2) Access Control System CCTV.
3) Department policy in place for identifying visitors.
4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.
~~6)~~**7) Unique Visitor Badge identification for visitors.**

iv. Neonatal Intensive Care Unit:
1) Electronic access control.
~~1)~~**2) Panic buttons.**
~~2)~~**3)** The Maternal Child Health units are protected with both active video surveillance systems on entrances and exits of the units. Additionally, the unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs.

v. Pharmacy Department:
1) Electronic access control.
2) Infrared Security System.
~~2)~~**3) Panic buttons.**

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

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

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

ix. ~~Patient Representative Office~~**Case Management**:
1) Panic button**s**.

9. Management of Security Incidents Including an Infant or Pediatric Abduction (SEC.EC.02.01.01 EP9)

a. The ~~Security Manager~~**Director of Security** has developed procedures for rapid response to breaches of security. The on-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The ~~Security Manager~~**Director of Security** or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

b. The ~~Security Manager~~**Director of Security**, Safety Officer and the Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
i. All available staff responds per the Patient Care Services Code Adam.
ii. The Code Adam plan is tested at least annually and the responses are

documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.

d. The ~~Security Manager~~**Director of Security** and the Director of Women and Newborn Services are required to conduct at least one abduction drill annually. In addition, activations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

10. The hospital monitors conditions in the environment (EC.04.01.01 EP1 – EP11)
    a. The Director of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The ~~Security Manager~~**Director of Security** works with the Director of Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.
    b. Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, the Director of Risk Management and the ~~Security Manager~~**Director of Security** collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health **&and** Safety Committee and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
    d. The ~~Security Manager~~**Director of Security** works with the Environmental Health **&and** Safety Committee to collect information about security deficiencies and opportunities for improvement from all areas of ~~Tri-City Healthcare District~~**TCHD**. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.
    e. The Environmental Health **&and** Safety Committee and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.
    f. The Safety Officer and the Patient Safety Committee prepare a quarterly report to the leadership of ~~Tri-City Healthcare District~~**TCHD**. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out.

11. Every twelve months the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)
    a. The Safety Officer coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each EC program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual

evaluation uses a variety of information sources.

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

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

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

12. Analysis and actions regarding identified environmental issues (EC.04.01.03 EP1 – EP3)
    a. The Environmental Health **&and** Safety Committee receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment (EC.04.01.05 EP1 – EP3)
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the Environmental Health **&and** Safety Committee recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The Environmental Health **&and** Safety Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The Environmental Health **&and** Safety Committee also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training (LD.03.01.01 EP6 **&and** EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – EP3)
    a. Orientation and training addressing the environment of care **and workplace safety** is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care **and workplace safety** in accordance with the Medical Staff policies and bylaws.
    b. In addition, annual **Environment of Care and workplace safety**~~EOC~~ training is provided and documented via NetLearning.
    c. The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program. New employees are required to attend the general NEO orientation program within 30 days of their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.

d. New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.

e. The Safety Officer collaborates with the Environment of Care leaders, the Director of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each Environment of Care program and revised as necessary.

f. The Safety Officer gathers data during **environment of care** ~~environmental EOC~~ rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. The **environment of care**~~EOC~~ ~~Rounds~~ **rounds** evaluate the degree to which staff and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

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

F. **GOALS AND OBJECTIVES FOR ~~FY2017~~FY2018:**

~~1. Complete an assessment of the parking lot camera coverage with HCI and create and action plan for installation of cameras throughout the campus to improve visibility of the parking lot. Add signage throughout the parking lot alerting individuals that cameras are in use.~~

~~2. Creation of the Outpatient Psychiatric Crisis Stabilization Unit (CSU) in BHU. Measure of success will be the unit is opened and operational with CDPH approval.~~

~~3. Add the following safety precautions to the CSU for both patient and staff safety:~~

~~a. Fixed post officer~~

~~b. Cameras and monitors to improve observation of the patients~~

~~c. Add key pad door locks to strengthen access control to key locations~~

~~d. Creation of a new close observation room on the Inpatient side (pending OSHPD approval)~~

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

1. Patient Care Services: Code Adam Policy

H. **REFERENCE(S):**

1. The Joint Commission **Environmental of Care** Standards
2. Cal/OSHA Workplace Violence Prevention ~~requirements~~**in Healthcare, Title 8, Chapter 4, § 3342 regulations**

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

Delete Policy: Follow Patient Transport Express Policies 529, 527, and 530

SUBJECT: Transportation of Patients

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13

Department Approval:	12/16
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	11/17
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To meet the transportation needs of the patients attending Behavioral Health Outpatient Programs.~~

~~B. **POLICY**~~

~~1. Transportation of patients to and from Outpatient Behavioral Health Services may be provided or arranged for daily. Only appropriately licensed and approved drivers in authorized vehicles will provide transportation services. Private vehicles of staff are not authorized for the transport of patients.~~

~~C. **PROCEDURE**~~

~~Who may perform/responsible: Tri-City Medical Center Transportation Staff~~

~~1. The Transportation Dispatcher or designee is responsible for compiling the list of patients scheduled each day and determines the routes for the Outpatient Behavioral Health vans.~~
~~2. The list of patients scheduled is given to the drivers for their daily pick-ups. The transportation schedule is also sent to Patient Transportation Express at Tri-City Medical Center for coordination with their schedule.~~
~~3. Patients may provide their own transportation if they choose.~~
~~4. In the event of a late physician visit, alternate transportation, such as yellow cab may be used with the consent of the patient.~~
~~5. Routine medical and dental appointments should be scheduled outside program hours, wherever possible. Patients are expected to provide or arrange for their own transportation to such appointments. The nurse and staff may assist in scheduling the appointment if the patient, or person assisting with care, is not able to follow through.~~
~~6. In the event of an emergency during program hours or other exceptional circumstances requiring transportation during program hours, the Transportation Dispatcher or designee will assist in making the appropriate arrangements.~~
~~7. Please refer to the Patient Transport Express Policies and Procedures for details on vehicle maintenance and other transportation topics.~~

Tri-City Medical Center
Oceanside, California

DELETE: Incorporated into Patient Care Services: Pet Therapy Policy

REHABILITATION SERVICES ~~POLICY MAN~~

SUBJECT: PET THERAPY - TENDER LOVING CANINES

ISSUE DATE: 7/89
REVISION DATE(S): 1/91, 9/91, 6/92, 11/92, 11/94, 9/97, 2/03, 1/06, 1/08, 1/09, 11/09, 5/11, 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:	11/17
Board of Directors Approval:	

~~**ISSUE DATE:** 7/89~~

~~**REVISION DATE:** 1/91, 9/91, 6/92, 11/92, 11/94, 9/97, 2/03, 1/06, 1/08, 1/09, 11/09, 5/11, 5/12~~
~~**REVIEW DATE:** 9/95, 4/97, 1/00, 8/11~~

~~**SUBJECT: PET THERAPY – TENDER LOVING CANINES**~~

~~**STANDARD NUMBER: 903**~~

~~**CROSS REFERENCE:**~~
~~**APPROVAL:** ICC 5/90, 3/91, 11/94, 9/97, 1/00,3/03, 3/06~~
~~MEC 7/90, 3/91, 11/94, 9/97, 1/00~~

~~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.~~ ~~**POLICY AUTHORIZED TO PERFORM SERVICE::**~~

~~**1.**~~ ~~**All patients of Tri-City Medical CenterHealthcare District (TCHD), per Patient Care Services: Pet Therapy Policy are eligible for participation in the program, with permission of the physician in order to promote cognitive skills, physical functioning and improve patient psycho-social well-being.**~~

~~**1.2.**~~ ~~**Only** Active members of Tender Loving Canines (TLC) Program. Dogs **are authorized to perform service with dogs** and handlers who are registered with Pet Partners, Independent Therapy Dogs, Inc., or other therapy dog certifying agencies approved by Tri-City Medical Center**TCHD.**~~

~~B. PURPOSE~~

~~1. To promote patient cognitive skills; attention to task, problem solving, short and long term memory.~~
~~2. To improve patient physical functioning; strength and endurance, coordination, balance, fine and gross motor skills, body awareness, tactile stimulation, hand-eye coordination.~~
~~3. To improve patient psycho-social well-being; brighten affect and mood, increase interaction and verbalization, expression of feelings, reality orientation.~~

~~C. ORGANIZATION~~

~~1. The Ad Hoc committee of the TLC program shall consist of at least a nurse representative from the unit involved, animal behavior authority, therapeutic recreation~~

~~staff, occupational therapist, infection preventionist (advisory), doctor (advisory), a veterinarian (advisory), and auxiliary coordinator.~~

~~2. The chairpersons will call meetings as needed to review policies and procedures, discuss program updates, review TLC memberships, etc.~~

~~D. POLICY~~

~~1. All patients of Tri-City Medical Center (TCMC) Acute Rehabilitation Unit, inpatient and outpatient Behavioral Health Services, Tri-City Hospice, Cardiac Wellness, Stroke program, Pediatric Outpatients, and Oncology are eligible for participation in the program, with permission of the physician.~~

~~2. For shared-room. The dogs and handlers may visit in the room only if both patients have doctors' approval. If not, the visit will be set up in a different area for the patient with doctor's approval. Accommodation will be made to address rights of patients sharing a room.~~

~~3.~~ ~~Dogs may not visit~~ ~~**the following rooms:**~~

~~a.~~ ~~**Shared rooms, unless both patients have doctor's approval and agree.**~~

~~b.~~ ~~**Patients with** TB patients, patients; **dogs and their handlers can acquire TB.**~~

~~3.c.~~ ~~**Patients** with spleens removed or MRSA-positive patients. Pet therapy will not be utilized for inpatients colonized or infected with VRE, Salmonella, Campylobacter, Shigella, Strep A, Ringworm, Giardia, or Amebiasis. ; patients with spleens removed are susceptible to DF-2, a gram-negative rod that is a normal inhabitant of dog saliva. Dogs and their handlers can acquire TB and MRSA. Please check with Infection Control before permitting pet visits for patients in various immune deficiency states. Nurses will provide handlers and Pet Therapy Program with names of those patients who should not have visits for these reasons.~~

~~4. After approval for pet visits by the medical staff in designated areas, unit directors are ultimately responsible for the care on their units. For smooth operational flow, pet therapy is subject to the convenience of nursing with appropriate consultation and coordination through pet therapy.~~

~~5. Prior to initiating pet visits on any new area of the hospital, the unit must be approved to receive visitation by the medical staff. Unit Directors shall receive a copy of the guidelines and P&P's benefits of pet therapy. The decision for a unit to participate in pet therapy will be left up to the individual unit director. Any problems identified with pets or their handlers while on a unit should be directed to that unit's director. The concerns will be directed to the TR Specialist or the Pet Therapy Committee, for follow-up and resolution.~~

~~E. EQUIPMENT~~

~~d.~~ ~~**Patients who test MRSA positive; Dogs and their handlers can** acquire **MRSA**~~

~~e.~~ ~~**Patients colonized or infected with VRE, Salmonella, Campylobacter, Shigella, Strep A, Ringworm, Giardia, or Amebiasis.**~~

~~f.~~ ~~**Infection Control must be consulted before permitting pet visits for patients in various immune deficiency states.**~~

~~4.~~ ~~Dog's Equipment:~~

~~a. Acceptable equipment:~~

~~(1)a.~~ ~~Well-fitted buckle, quick-release connection, or snap closure red collar and harness made of leather or fabric.~~

~~i.~~ ~~**all metal/chain or slip collars may not be used.**~~

~~ii.~~ ~~**Special training collars such as pinch, spike, electric or spray may not be used**~~

~~(3)b.~~ ~~Collars may be flat collars or Martingales (i.e. limited slip collar).~~

~~a.c.~~ ~~Halters may be Gentle Leader, Promise, Snoot Loop or Halti and may only be used at the discretion of the animal behaviorist.~~

~~i.~~ ~~**Metal chain and retractable leashes may not be used (ie Flexi-Leash).**~~

~~(4)d.~~ ~~Metal buckles, slip rings, and D-rings are acceptable.~~

~~(5)e.~~ ~~All leather or fabric red leashes, no more than 6' in length.~~

~~b.Unacceptable equipment~~

~~(1) Metal collars and harnesses, including Martingales with metal links.~~
~~(2) Slip collars of any type.~~
~~(3) Special training collars, such as "pinch", "spike", "electric", or spray collars.~~
~~(4) Metal chain and retractable leashes (i.e. Flexi-Leash).~~

~~5.~~ ~~Handler's Attire:~~
~~a.~~ ~~Clothing~~
~~(1)i.~~ ~~Clothes are to be neat and tidy and may not include shorts, blue jeans, short skirts or tight-fitting clothing.~~
~~(2)ii.~~ ~~Shoes must be closed-toed.~~
~~(3)iii.~~ ~~No accessories or jewelry that may have sharp edges or corners.~~
~~b.~~ ~~TLC Uniforms:~~
~~(1)i.~~ ~~Red TLC vest and/or approved TLC logo shirt~~**~~attire~~** ~~is to be worn by handler at all times when present in the facility on a visit with their dog.~~
~~(2)ii.~~ ~~TCMC~~ **~~TCHD~~** ~~ID badge and Pet Therapy ID badge from approved TCMC~~ **~~TCHD~~** ~~Pet Therapy certification/registration agency, both to be worn at all times on vest and/or approved TLC logo shirt or on a lanyard.~~

~~B.~~ ~~**PROCEDURE:**~~
~~F.1.~~ ~~General Guidelines:~~
~~1.a.~~ ~~All handlers must be at least 18 years of age.~~
~~2.b.~~ ~~TLC is the only group sponsoring pets in the hospital that is supported by the medical staff. Dogs that have not been screened are not sponsored by TLC in the hospital. Dogs must be at least one year of age to start in the program and have been with the handler for at least 6 months.~~
~~3.c.~~ ~~Handler is required to become a member of the TCMC~~ **~~TCHD~~** ~~Auxiliary, which includes the following:~~
~~a.i.~~ ~~Yearly membership dues~~
~~b.ii.~~ ~~Background check~~
~~c.iii.~~ ~~TB screening~~
~~d.iv.~~ ~~Hospital Orientation~~
~~i.v.~~ ~~Annual auxiliary refresher course~~
~~b.d.~~ ~~Admittance to the TLC program requires a TCMC~~**~~TCHD~~**~~-approved process, each step of which must be fully completed for the application to be accepted. The procedure consists of the following process:~~ **~~approval and supervision by Pet Therapy Coordinator~~**~~.~~
~~c.e.~~ ~~Health tests are required for the handler and~~ **~~, per TCMCHD volunteer policy for health screening and~~** ~~dog,~~ **~~signed off by veterinarian, per attached form~~** ~~and fleas~~**~~submitted to Pet Therapy Coordinator.~~**
~~4. Handler will complete TCMC Pet Therapy Application.~~
~~5. Handler will submit proof of certification/registration from TCMC approved certification/registration agency to Pet Therapy Coordinator.~~
~~6. Proof of certification/registration must include TCMC approved Pet Therapy certification/registration health screening form signed by veterinarian.~~
~~7. Handler:~~
~~(1) The handler will follow TCMC guidelines for initial TB screening to begin hospital work and a skin test done yearly thereafter.~~

~~a. Dog:~~
~~(1) Physical Examination - A thorough physical examination must be performed by a licensed veterinarian. The vet should record any overt signs of diseases or abnormality of integumentary, musculoskeletal, cardiovascular, alimentary, respiratory, urogenital, or nervous system using the TLC/Pet Partners or approved health screening form.~~
~~(2) The dog should be free from signs of infectious disease and chronic or debilitating diseases,~~

~~(3) Vaccination History - The dog should have a record of vaccinations within one year but at least two or more weeks prior to entry into the program. Vaccinations recommended: Rabies, Distemper, Hepatitis, Leptospirosis, Parvovirus, and Parainfluenza.~~

~~(4) Clinical Pathological Exam: The dog should have a normal complete blood count and chemistry screen.~~

~~(5) Examination for Endoparasite: One or two fecal exams, including microscopic exam of floatation direct smears should be negative for Toxocara canis, and Giardia spp.~~

~~(6) Exam for Ectoparasite and Dermatophyte: The dog should be free of any evidence of fleas, mange mites (Sarcoptes), ticks, ear mites, or ring worm. Any skin lesions involving alopecia and or erythema should have a deep skin scraping taken from the edge of the lesion and examined microscopically for mites and cultured for dermatophyte.~~

~~(7) Exam for Heartworm - The dog should be free of heartworm. A modified Knott's test for microfilaria and a test for Dirofilaria antigen should be negative.~~

~~b. The veterinarian will obtain and perform the following:~~

~~(1) Complete Blood Count (Vet)~~

~~(2) Stool~~

~~(a) Ova & Parasites (Vet)~~

~~(b) Campylobactor jejune, and Salmonella jejuni (TCMC)~~

~~(3) Skin~~

~~(a) Fungal, if skin lesion present (Vet)~~

~~c. TCMC lab will complete the following:~~

~~(1) Serum~~

~~(a) Chemistry screen (VCP I)~~

~~d. The handler takes all samples provided to them by the veterinarian to the TCMC Laboratory within 1 hour of completion of the veterinary visit, following guidelines. All specimens are labeled with:~~

~~(2) Tri-City Medical Center TLC Dogs~~

~~(3) Attn: Pet Therapy Laboratory technician's name~~

~~(4) Date~~

~~(5) The dog's first name~~

~~(6) Dog's gender~~

~~(7) Handler's last name~~

~~(8) Veterinarian's name~~

~~(9) Unlabeled specimens will be discarded~~

~~8. A copy of the finalized test results will be given to the Pet Therapy Coordinator, who will send one copy to the veterinarian's office. The Pet Therapy Coordinator will obtain a final certification/packet signed by the veterinarian.~~

~~9.~~**f.** ~~The Handler will complete a Tri-City Medical Center~~**TCHD** ~~Pet Therapy application form and submit to the Pet Therapy Coordinator, pending approved trainee status. Certification/registration documents from Pet Partners, Independent Therapy Dogs, Inc., or other therapy dog certifying agency approved by Tri-City Medical Center~~**TCHD** ~~must be included with the application.~~

~~10.~~**g.** ~~All trainee members (handlers and dogs) will attend an orientation meeting prior to beginning hospital work. At the orientation meeting, they will receive handouts and/or information on all of the following~~ **conducted by Pet Therapy Coordinator**~~:~~

~~a. Handlers will be told what signs of illness to watch for in their dogs and themselves, and what to do in case they are observed. Handlers or dogs with symptoms of respiratory infections such as colds and flu shall call in and reschedule visits.~~

~~b. All dogs must be bathed within 24 hours prior to a visit. Dog should be groomed, teeth clean, and toenails recently trimmed and filed smoothly.~~

~~c. Proper attire for handlers and proper equipment for dogs.~~

~~d. Before arriving at the hospital, the handler will allow the dog ample time to exercise, urinate and defecate in an appropriate location not near any entrance to the hospital. Handler is responsible for proper removal and disposal of all fecal matter.~~

~~e. Pad softener must be applied prior to visits with patients.~~

~~f. The dog must be calm, under control, on a leash, and within the handler's sight at all times.~~

~~g. Before approaching each patient, the handler, nurse or therapist will ask if he/she would like a Pet Therapy visit. Dogs will not be allowed to jump up uninvited on staff or patients, their bed, or property, or to lick or bite patients, even in play. Approval from a therapist or nurse should be granted prior to the dog being allowed on the patient's bed. A blanket/towel will be placed on the bed if the dog is invited to sit/lie on patient's bed. After use, the towel/blanket will be put into the soiled laundry.~~

~~h. Patients will be provided with an alcohol towelette and/or disinfecting gel to wash their hands after a visit and will be assisted in doing so, if needed.~~

~~i. In case of a sanitary accident in the patient care area by the visiting dog, the handler will cover the area with an absorbent material, if available, and notify the nurse. Environmental Services will be called and will be responsible for cleaning and disinfecting the area.~~

~~j. In case of an emergency with the patient, the handler will immediately notify the nurse, and upon the nurse's arrival the handler and dog should leave the room. Handlers will notify Pet Therapy Coordinator within 24 hours and may call approved certifying agency if they have questions or concerns for recommendations for future consideration.~~

~~k. Handlers will be oriented to, and expected to follow, all hospital emergency evacuation procedures in case of fire or other disaster.~~

~~11.~~**~~h.~~** ~~Trainee handlers and their dogs should be accompanied by a certified handler or trained observer for a minimum of three (3) consecutive visits within 3 months of being accepted into the TLC program. Appropriateness of their behavior and awareness of TCMC~~ **~~TCHD~~** ~~policies will be assessed before being scheduled to make visits on their own to units. The visits will include one visit to the unit on which they will be volunteering. A trained observer is anyone who has received approval from the TLC Pet Therapy Coordinator.~~

~~12.~~**~~i.~~** ~~On a yearly basis, the dog must pass the above-mentioned physical exam for membership renewal.~~

~~G.~~**~~2.~~** ~~Scheduling by the TCMC~~ **~~TCHD~~** ~~Pet Therapy Coordinator:~~

~~d.~~**~~a.~~** **~~Handlers will coordinate and schedule visits with Pet Therapy Coordinator.~~**

~~1. Handlers will keep the Tri-City Pet Therapy Coordinator advised of their availability. Specific attributes and talents will be listed on the coordinator's roster such as: sulky pulling, small dog, big dog, long hair, short hair, catch or fetch. The coordinator will compile the visitation schedule and communicate with staff. A copy of the schedule will be sent to the charge nurse and/or Therapeutic Recreation Specialist.~~

~~2. Upon arrival at the hospital, the handler will sign in/out at the Auxiliary desk and check in/out at the nurses' station and will report any unusual incidents before they leave the unit.~~

~~3. If a handler or dog is sick (on the day of their scheduled visit or for three days before), the handler will call the coordinator to advise him or her of the situation as soon as possible. That handler's visits will then be reassigned or canceled by the coordinator.~~

~~4. A non-spayed female dog will not be scheduled to make a visit while in estrous (heat).~~

~~5. A total of at least 8-10 visits per year must be made by the handler and dog to be considered for yearly renewal and membership.~~

~~6. Any handler who does not follow proper procedures or a dog that is felt to be out of control or a nuisance may be asked to leave the hospital grounds immediately by the charge nurse (or designee) or a therapeutic recreation specialist, or, in the home health setting, the patient or family. The excused volunteer may be asked to appear before the governing board at the TLC board meeting and the incident reviewed for possible action as follows at the board's discretion.~~

~~H. SPECIAL CONSIDERATIONS~~

1. ~~Dismissal - after 3 months, a handler may reapply and be accepted with a majority of present vote.~~
2. ~~Leave of Absence - Length at the discretion of the board.~~
3. ~~Temperament Retest - Documentation may be required from an assigned animal behavior authority. There is no limit to retesting opportunities.~~
4. ~~Reorientation~~
5. ~~Health rechecks - Documentation may be required from an assigned veterinarian at the handler's expense.~~
6. ~~Demotion to trainee status.~~
7. ~~Obedience class - Documentation of successful completion of an assigned or accepted obedience class of any level may be required with subsequent completion of temperament.~~

~~C.~~ ~~REFERENCE(S):~~

1. ~~Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities. Recommendations of CDC and the Healthcare Infection Control Practice Advisory Committee (HICPAC). MMWR 2003; 52 (No.RR-10); 1-48.~~
2. ~~Lafebre et al. (2008). Guidelines for animal assisted intervention in health care facilities. AJIC, 36(2). P 78-85.~~
3. ~~Medical Evaluation Form for Dogs and Cats. Development, Implementation, and Evaluation of Animal-Facilitated Therapy Programs, Delta Society Conference, Oct. 4-6,1988.~~
4. ~~Prescription Pet Program, The Children's Hospital, Denver, Colorado. Veterinary Health Protocol, Initial Behavioral Evaluation, Assn. of Volunteers for Children's Hospital and the Denver Area Veterinary Medical Society, Sept. 1987.~~
5. ~~Proposal for Health Examination/Screening of Dogs - Pilot Pet Therapy Program. Barbara Deep, D.V.M., School of Animal Medicine, University of Washington, Oct. 1 1987.~~
6. ~~Proposal to Provide Animal Assisted Therapy Services to Canyon Springs Hospital. Delta Society, California Desert Chapter, April 1989.~~

~~**S L Duncan, RN.** *APIC State-of-the-Art Report: The Implications of Service Animals in Healthcare Settings;* The 1997, 1998, and 1999 APIC Guidelines Committees~~
~~AJIC Am J Infect Control 2000;28:170-80.~~
~~APIC text of *Infection Control Epidemiology*, 3rd Edition~~

Colloidal Oatmeal: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: Colloidal oatmeal (Aveeno) has not been ordered for several years and is not routinely stocked

Background: Colloidal oatmeal is an over the counter remedy that can be used to soothe dermatitis.

Assessment: Medication usage reports indicate that the product has not been used or ordered for several years. There are a variety of products including calamine lotion and emollient creams available on the TCMC formulary

Recommendation(s):

- Given lack of use and availability several alternatives, the P&T Committee approved the removal of colloidal oatmeal from the TCMC drug formulary at this time

Dicyclomine for injection: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: Dicyclomine IV has not been ordered for several years and a large supply of this product has recently expired in Pharmacy storage

Background: Dicyclomine is an anti-spasmodic used to reduce gastric motility and relieve irritable bowel symptoms

Assessment: Medication usage reports indicate that the product has not been used or ordered for several years. Dicyclomine comes in an oral formulation which is currently available on the TCMC formulary.

Recommendation(s):

- Given lack of use and availability of formulary alternatives for motility reduction, the P&T Committee approved the removal of dicyclomine for injection from the TCMC drug formulary at this time

Fentanyl lozenges (Actiq): Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: Fentanyl transmucosal lozenges (200 – 1200 mcg) have not been ordered in over two years and routinely expire in Pharmacy supply

Background: Fentanyl is an opioid agonist used for analgesia. The fentanyl lozenge formulation is intended for use in opioid tolerant patients for chronic pain management. Due to safety risks, the FDA enacted a Risk Evaluation Mitigation Strategy (REMS) called the Transmucosal Immediate Release Fentanyl (TIRF) REMS Access Program which requires prescribers and hospitals to maintain enrollment status to prescribe and dispense this product.

Assessment: Medication usage reports indicate that the product has not been used or ordered for over two years. Maintaining this product in Pharmacy supply results in a cost burden of approximately $1400 annually.

Recommendation(s):

- Given lack of use and availability of formulary alternatives for pain management, the P&T Committee approved the removal of fentanyl lozenges from the formulary at this time

- Providers who wish to prescribe this product may submit a Non-Formulary Use Request form. The Pharmacy Clinical Manager will review each request for appropriateness of therapy and ensure that the ordering provider is enrolled under the FDA REMS program

Lactase enzyme tablets: Recommendation for formulary removal

Requestor: Oska Lawrence, PharmD, BCPS, BCCCP (Pharmacy Clinical Manager)

Declared conflicts of interest: None

Situation: All stock of lactase enzyme tablets expired in early 2017.

Background: Lactase is an enzyme marketed as an OTC product in capsule, liquid, and tablet form for the indication of lactose intolerance.

Assessment: Lactase has not been ordered for a patient at this institution for several years. Providers have the ability to order lactose-free diets from the Nutrition Service for lactose intolerant patients that are admitted.

Recommendation(s):

- Given lack of use and availability of an appropriate lactose-free diet for patients, the P&T Committee approved the removal of this OTC product from the hospital formulary

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Governance & Legislative Committee Meeting Minutes
Tri-City Healthcare District
November 7, 2017

Members Present:	James J. Dagostino, PT, DPT, Chairperson; Director Laura E. Mitchell; Dr. Victor Souza, Chief of Staff ; Cary Mells, Physician Member
Non-Voting Members:	Steve Dietlin, CEO; Kapua Conley, COO; Susan Bond, General Counsel; Carlos Cruz, CCO
Others Present:	Teri Donnellan, Executive Assistant; Greg Moser, Board Counsel
Absent:	Director RoseMarie V. Reno; Robin Iveson, Community Member; 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.		
2. Approval of Agenda	**It was moved by Director Mitchell and seconded by Dr. Souza to approve the agenda as presented. The motion passed unanimously by those members present.**	Agenda approved.	Ms. Donnellan/
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 Dr. Souza to ratify the minutes of the October 3, 2017 Governance & Legislative Committee. The motion passed unanimously by those members present.**	Minutes ratified.	Ms. Donnellan
5. Old Business a. Review and discussion of Board Policy 17-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms	Ms. Sharon Schultz, CNE stated some additional revisions were made to Policy 17-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms to provide clarification. Section II E. Rules for Use 5. was amended to include		

Topic	Discussion	Action Follow-up	Person(s) Responsible
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	"Saturdays may be available at additional cost". Ms. Schultz explained additional staff time would be incurred for meetings held on Saturdays. Section III A. and D. were amended to include *"the room scheduler/event coordinator".* Section III C. was amended to reflect that *"unusual" room requests require approval by the CNE".* Ms. Schultz explained that we prefer to rent meeting space to outside groups that tie into the hospital's mission. Section III F. was clarified to reflect "*that a cancellation fee will be charged for any costs incurred by the District prior to the cancellation of an event"* such as table rentals. Section III G. was also clarified to reflect that "*a deposit will be refunded in the event the District needs to cancel a scheduled meeting group"*, although typically there are no charges until the event has been completed. **It was moved by Dr. Souza to recommend approval of Board Policy 17-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms. Director Mitchell seconded the motion. The motion was passed unanimously by those members present.** *Ms. Schultz left the meeting at 12:37 p.m.*	Recommendation to be sent to the Board of Directors to approve Board Policy 17-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms; item to be placed on agenda and included in agenda packet.	Ms. Donnellan
b) Review and discussion of Board Policy 17-001 – Budget for Medical Equipment or Medical Services	In follow-up to last month's meeting, Board Policy 17-001 was placed on the agenda for clarification. Chairman Dagostino stated the budget is discussed and approved in open session of the Board. Mr. Dietlin explained that the capital budget does not pass through the Medial Executive Committee specifically but is communicated to the MEC through the Chief of Staff who is involved in the strategic planning process. Mr. Moser stated state law is changing next year and will require districts to adopt a budget which the District already does. Mr. Dietlin commented that all lenders		

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	require that a budget be adopted and that is done in a public forum. Members of the Medical Staff on the committee stated they were comfortable with the budget process and did not have any qualms in abolishing Board Policy 17-001. **It was moved by Director Mitchell and seconded by Dr. Souza to strike Board Policy 17-001 – Budget for Medical Equipment or Medical Services. The motion was passed unanimously by those members present.**	Recommendation to be sent to the Board of Directors to strike Board Policy 17-001 – Budget for Medical Equipment or Medical Services; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
c) Update of TCHD Implied Consent Procedures	At a previous meeting the committee requested that Ms. Bond review TCHD's implied consent procedures to ensure we are compliant. It was clarified that the procedures are not included in the agenda packet and are not being discussed today for approval, but simply as an informational item. Ms. Bond stated California does have an Implied Consent Law and individuals must comply with the law when law enforcement has probable cause to stop a licensed driver for driving while intoxicated. Dr. Mells stated there is still some lack of clarity if blood can be drawn if the patient refuses or is unconscious. He questioned if the patient should be restrained to comply with the law. The question was also raised as to whether blood could be drawn without consent if the patient is not under arrest. It was recommended that Ms. Bond meet with Dr. Mells and the Director of the Emergency Department to clarify the administrative legal issues and bring forward to the MEC and the Professional Affairs Committee for approval.	Ms. Bond to meet with Dr. Mells and ED Director to clarify administrative legal issues related to implied consent; procedure to be amended if applicable and brought forward to MEC and the Professional Affairs Committee..	Ms. Bond; Dr. Mells; ED Director; MEC; PAC
6. New Business a) Medical Staff Rules	Ms. Sherry Miller, Manager of the Medical Staff Office stated the Department of Pediatrics and Department of Radiology Rules & Regulations are being updated to		

Topic	Discussion	Action Follow-up	Person(s) Responsible

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Regulations 1) Department of Pediatrics 2) Department of Radiology	comply with Joint Commission requirements. With regard to Emergency Department coverage, Ms. Miller stated there is a "blanket" Emergency Department Call policy that applies to all Medical Staff Departments and Divisions. Dr. Mells questioned if each department maintains control of whether they want to use Allied Health Professionals. Ms. Miller confirmed that is the case. She also confirmed that the language related to the Quality Assurance Patient Safety and Performance Improvement Committee has been updated in the Medical Staff Bylaws to accurate reflect the name of the Committee. **It was moved by Dr. Souza and seconded by Director Mitchell to recommend approval of the Department of Pediatrics and Department of Radiology Rules & Regulations as presented. The motion passed unanimously by those members present.** *Ms. Miller left the meeting at 12:55 p.m.*	Recommendation to be sent to the Board of Directors to approve the Department of Pediatrics and Department of Radiology Rules and Regulations as presented; items to be included on Board agenda and added to agenda packet.	Ms. Donnellan
b) Consideration to amend relevant Board Policies to reflect language change from General Counsel to Board Counsel 1) Policy 17—009 – Requests for Information or Assistant by Board Members 2) Board Policy 17-010 – Board Meeting agenda Development, Efficiency and Time Limits for Board Meetings, Role and Powers of Chairperson 3) Board Policy 17-011 – Placement of Items on Committee agendas	Chairman Dagostino reported the policies listed on today's agenda require modifications to reflect the current roles by Board Counsel and General Counsel. He explained that Susan Bond has been appointed General Counsel and will continue to report to Mr. Dietlin. Mr. Moser is Board Counsel. No additional revisions were suggested to Policy 17-009. It was suggested that Section I. first sentence be amended to include "*and Chief Compliance Officer as needed*". No additional revisions were suggested to Board Policy 17-011.		

Topic	Discussion	Action Follow-up	Person(s) Responsible
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4) Board Policy 17-021 – Use of Legal Counsel by Members of the Board of Directors	Chairman Dagostino stated it is important for the Board to have their own counsel and the Board Chair is the direct line to Board counsel.		
5) Board Policy 17-022 – Maintenance of Confidentiality by Directors and Committee Members 5) Board Policy 17-042 – Duties of the Board of Directors 6) Board Policy 17-023 – Responsibility for Decision-making on Legal Matters	No additional revisions were suggested to Board Policy 17-022. No additional revisions were suggested to Board Policy 17-042. Chairman Dagostino stated Board Policy 17-023 was modified to reflect the correct Job Description for Board Counsel. Mr. Moser stated Section 1. b. was modified to give the CEO more discretion in securing legal opinions without calling a Board Meeting to do so. **It was moved by Director Mitchell and seconded by Dr. Souza to recommend approval of Board Policies 17—009 – Requests for Information or Assistant by Board Members, 17-010 – Board Meeting agenda Development, Efficiency and Time Limits for Board Meetings, Role and Powers of Chairperson, 17-11 – Placement of Items on Committee agendas, 17-021 – Use of Legal Counsel by Members of the Board of Directors, 17-021 – Use of Legal Counsel by Members of the Board of Directors, 17-022 – Maintenance of Confidentiality by Directors and Committee Members, 17-042 – Duties of the Board of Directors, 17-023 – Responsibility for Decision-making on Legal Matters. The motion passed unanimously by those members present.**	Recommendation to be sent to the Board of Directors to approve Board Policies 17—009 – Requests for Information or Assistant by Board Members,) 17-010 – Board Meeting agenda Development, Efficiency and Time Limits for Board Meetings, Role and Powers of Chairperson, 17-011 – Placement of Items on Committee agendas, 17-021 – Use of Legal Counsel by Members of the Board of Directors, 17-021 – Use of Legal Counsel by Members of the Board of Directors, 17-022 – Maintenance of Confidentiality by Directors and Committee Members, 17-042 – Duties of the Board of Directors, 17-023 – Responsibility for Decision-making on Legal Matters; items to be placed on Board agenda and included in agenda packet.	Ms. Donnellan

Topic	Discussion	Action Follow-up	Person(s) Responsible

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c) Consideration to amend Bylaws to reflect language change from General Counsel to Board Counsel	Chairman Dagostino stated minor revisions have been made to the Bylaws as well to reflect language change from General Counsel to Board Counsel. In addition to the revisions presented, Mr. Moser recommended Article IV, Section 10 k. 8. be struck as it is not possible for the Board to remove a Board member. Dr. Mells requested clarification on Article III, Section 7, Absences from Meetings. Mr. Moser stated the language in Section 7. conforms with the way the law is written. **It was moved by Director Mitchell to recommend approval of the Bylaws as amended. Dr. Mells seconded the motion. The motion passed unanimously by those members present**	Recommendation to be sent to the Board of Directors to approve the Bylaws as amended; item to be placed on Board agenda and included in agenda packet.	Ms. Donnellan
7. Discussion regarding Current Legislation	Mr. Moser reported there are two bills that may impact operations. SB 241 which was signed by the Governor harmonizes state law with certain provisions of federal health information privacy regulations adopted under the Health Insurance Portability and Accountability Act of 1996. SB 351 which has also been signed by the Governor provides additional options for hospitals to license pharmaceutical services in a satellite or approved service area located separate from the hospital's physical plant that is not under the hospital's consolidated license. Chairman Dagostino questioned if SB 790 would interfere with testing that we do. Dr. Mells stated there are exceptions that include sponsorship of significant educations seminars, bona fide clinical trials and support to free clinics.	Information only.	
8. Review of FY2018 Committee Work Plan	The FY2018 Committee Work Plan was included in the agenda packet for information.	None	

Topic	Discussion	Action Follow-up	Person(s) Responsible

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9. Committee Communications	There were no committee communications.		Ms. Donnellan
10. Committee Openings – None	There are no committee openings.		
11. Confirm date and time of next meeting	Chairman Dagostino reported the committee will begin meeting quarterly. The committee's next meeting is scheduled for Tuesday, January 2, 2018 at 12:30 p.m.	The next meeting of the Committee is January 2, 2018 at 12:30 p.m.	
12. Adjournment	Chairman Dagostino adjourned the meeting at 1:26 p.m.		

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

~~**BOARD POLICY #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 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: 9/25/17
Reviewd by the Gov/Leg Committee: 12/5/17
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~17-009

POLICY TITLE: Requests for Information or Assistance by Board Members

1. Requests for information or assistance by individual Directors requiring more than 15 minutes of staff time shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. All questions regarding confidentiality and privilege shall be directed to the ~~General~~ Board Counsel, Compliance Officer or their designees. All requests shall be stated clearly and shall be specific. In making requests, Directors shall keep in mind that District staff time and resources are both limited and expensive, and that staff members have other duties.

2. All requests for information which concern another Director shall be directed in writing to the Chairperson of the Board, with a copy to the President/CEO or his/her designee. A copy of the written request shall be directed to all members of the Board including the member concerning whom information is requested, along with any information provided in response to the request.

3. All requests for information relating to Closed Session materials, including requested inspection, shall be directed to the Chairperson of the Board, with a copy to the President/CEO or his/her designee and shall be subject to the confidentiality provisions of Policy #022.

4. Requests for information and assistance shall receive a response as soon as reasonably possible, although not necessarily immediately. The President/CEO shall have the final authority to determine by what means and when District staff responds to the request. If, in the judgment of the Chairperson of the Board or the President/CEO, the request requires a material amount of employee time or the request includes information or documents which are confidential or privileged or the request is one which is deemed appropriate for Board consideration, the President/CEO or Chairperson may ask for a decision from the full Board of Directors before action is taken.

5. Should any Director's request for information or analysis require more than 30 minutes of staff time, the Chairperson or the CEO may require the Director to secure Board approval for the work.

6. This Policy shall not preclude the Chairperson from exercising authority granted under District Bylaws or Board Policy: Role and Powers of Chairperson. Nothing in this policy shall be construed to limit the rights of a Director under the Public Records Act.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07

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: 11/7/17

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #17-010

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

I. BOARD MEETING AGENDA DEVELOPMENT

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

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

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

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

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

II. EFFICIENCY OF BOARD MEETINGS

The Board of Directors and management shall work cooperatively to prepare for and manage Board meetings in a manner that produces efficient and effective meetings (See Policy #~~10~~17-39). To achieve that end, the following process will be followed:

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

B. Board members who require further information or clarification on Board Agenda packet materials are welcome to contact the President/CEO, Board Counsel or ~~or~~ General ~~Board~~ Counsel with questions prior to the meeting. Responses shall be presented to all Board members at the Board meeting.

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

III. TIME LIMITS FOR BOARD OF DIRECTOR MEETINGS

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

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

IV. ROLE AND POWERS OF CHAIRPERSON

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

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

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

Approved by the Board of Directors: 8/25/16
Reviewed by the Governance Committee: 9/5/17 (no action taken)
Reviewed by the Governance Committee: 11/7/17
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~17-011

POLICY TITLE: Placement of Items on Committee Agendas

Items may be placed on the Agenda of a Committee of the Board in the following ways:

1. By action of the Board of Directors.
2. By action of the Committee itself at a prior meeting.
3. By the Chairperson of the Committee.
4. By the President/CEO, after consultation with the Chairperson of the Committee.
5. By any Director who is a member of the Committee, after consultation with the Chairperson of the Committee.
6. By any other Director, after consultation with the Chairperson of the Committee.
7. By a member of the Administration, with the consent of the President/CEO, after consultation with the Chairperson of the Committee.
8. By any member of a Committee after consultation with the Committee Chairperson.

The Agenda shall be developed by the Chairperson of the Committee, with the assistance of ~~General~~ Board Counsel and administrative staff if needed. Except for items placed on a Committee Agenda by action of the Board of Directors or the Committee itself, all requests must be submitted in writing to the Chairperson of the Committee or the President/CEO or their designees. The District's ~~Legal~~ Board Counsel will formulate the Agenda item in a format that conforms to legal requirements.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 6/4/13
Approved by the Board of Directors: 6/27/13
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 11/7/17
Aproved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~14~~17-021

POLICY TITLE: Use of ~~Legal~~ Board Counsel by Members of the Board of Directors

In order to control legal costs, the Board policy is to permit use of ~~General~~ Board ~~Legal~~ Counsel by individual Directors only as follows:

I. An individual Director may initiate consultation with ~~General Legal~~ Board Counsel regarding the following:

A. A legal matter relating directly to District or Board business, but not for matters personal to the Director or matters adverse to the interests of the District or the Board as a whole. Consultation must be limited to relatively simple questions which relate directly to the statutory authority of the Board or to procedures applicable to the Board and which do not require a written opinion or significant amounts of legal or factual analysis.

B. Any other legal matter relating directly to District or Board business, with prior approval of the Chairperson of the Board.

II. An individual Director may initiate consultation with outside special legal counsel at the expense of the District only: (1) when approved by the Chairperson of the Board; and (2) when ~~General Legal~~Board Counsel has a conflict of interest, potential conflict of interest, or there would be an appearance of impropriety, or ~~General Legal~~ Board Counsel lacks sufficient expertise regarding a legal matter relating directly to District or Board business; and (3) the matter is not personal to the Director or adverse to the interests of the District or the Board as a whole; (4) or when authorized by the Board.

III. Nothing in this Policy shall prohibit an individual Director from seeking the advice of ~~General Legal~~ Board Counsel on issues related to the Director's individual FPPC Form 700, or other relatively simple conflict of interest questions related to the individual Director.

IV. The Chairperson may initiate consultation with ~~General Legal~~ Board Counsel or outside special legal counsel in accordance with paragraphs I or II, above.

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by Gov/Leg Committee: 10/12/10
Approved by the Board of Directors: 11/04/10
Reviewed by the Gov/Leg Committee: 4/01/14

Approved by the Board of Directors: 4/24/14
Reviewed by Gov/Leg Committee: 11/7/17
Approved by Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #-~~14~~17-022

POLICY TITLE: Maintenance of Confidentiality by Directors and Committee Members

I. STATEMENT OF POLICY

Directors and Board Committee Members have access to private or confidential information. Both the law and sound business and legal practices require that confidentiality be maintained and protected for so long as it is necessary and appropriate in the interests of the District. In addition, such information is to be accessed and used by Directors and Committee Members only in their official capacity as public officials. It is important that Directors, Committee Members and staff be free to share confidential and/or privileged documents and information without concern for a breach of confidentiality. The use of a patient's protected health information is specifically addressed in the medical center's Notice of Privacy Practice and other HIPAA policies. These policies cover Medical Center employees, physicians, business associates as well as Directors and Committee Members. Moreover, improper disclosure of such a document or information by a Director or Committee Member may change the legal status of the matter disclosed, which may prejudice the District, the public, an employee, or a patient. That disclosure could also generate legal liability and/or financial penalties on the part of the District.

II. QUALITY MANAGEMENT

Effective peer review and quality management cannot be achieved unless the confidentiality of all discussions, deliberations, records and other information generated in connection with these activities is maintained, consistent with applicable law. Such confidentiality ensures the candid participation of staff members, Directors and Committee Members in these activities which are critically important for the evaluation and improvement of the quality of care rendered throughout the Tri-City Healthcare District (TCHD). Public officials must respect and maintain the confidentiality of all discussion, deliberations, records and information related to these activities. Such documents and information must be treated as confidential and must not be disclosed to or discussed with any person other than another Director or Committee Member without authorization by the Board or by the President/CEO.

III. PROTECTED HEALTH INFORMATION

Minimum necessary protected health information (PHI) required for Board actions may be provided to Board members. This will include access for treatment, payment, or operations. All others access must be authorized by the patient/patient representative. No re-disclosure of the PHI is allowed. Violations of this Section shall fall within the provisions of Sections VI and VII, herein.

IV. LEGAL AND OTHER CONFIDENTIAL/PRIVILEGED DOCUMENTS AND INFORMATION

Public officials may have access to documents and information which are confidential, private, or privileged under applicable law. Examples are documents and information related to pending litigation, personnel records and actions, and trade secrets. Such documents and information must be treated as confidential and must not be disclosed to or discussed with any person other than another Director or Committee Member without authorization by the Board or by the President/CEO. Medical staff applications and related records and information are confidential. Disclosure is prohibited without the prior written consent of the Chief of the Medical Staff or the applicant, unless specifically authorized in writing by the Board of Directors or the President/CEO.

V. CLOSED SESSION DOCUMENTS AND INFORMATION

Pursuant to Government Code section 54950, et seq. and other applicable law, the District is permitted to maintain the confidentiality and/or privilege of documents and information distributed, discussed, or prepared in a closed session of the Board or Committee. Such documents and information must be treated as confidential and must not be disclosed to or discussed with any person other than another Director or Committee Member without authorization by the Board. Any written materials, documents, or records distributed during the session or prior to the closed session for consideration at the session will be collected during the session and may not be removed by any Director, Committee Member, or other persons attending the session, from the session without authorization by the Board or the ~~General~~ Board Counsel.

A. Members of the Board and other persons admitted to closed sessions of the Board or its Committees shall not make or attempt to make any audio or video recording of any portion of the closed session. They also shall not make or attempt to make any verbatim copy (whether by long hand or other method) of any confidential or privileged materials without the authorization of the Board. A verbatim copy is defined as a copy which corresponds at least approximately word for word with the closed session material or any portion thereof.

B. It is the responsibility of any person in attendance during a closed session of the Board or its Committees who, at or after the session, notes or records his/her understanding or recollection of any matter discussed, distributed or available during the session, to maintain the confidentiality and security of the note or record. It is also that person's responsibility to refrain from discussing or disclosing the contents of any such note or record with anyone outside of a closed session of the Board or the Committee, without the authorization of the Board.

C. This Policy applies to any recording, copy, note or other record in any form regarding any action taken, oral statement made, or confidential or privileged document or other written material discussed or distributed at or available during the closed session, including but not limited to, an overhead transparency or computer projection or audio or video playback.

D. Directors may inspect Closed Session materials in the Administrative offices subject to this Policy relating to the maintenance of confidentiality by Directors. In the Administrative offices, Directors must sign-in and sign-out, including the date and time of inspection of Closed Session materials. Directors, in reviewing the Closed Session materials, cannot take any verbatim copy (whether by long hand or other method), notes, copies, or photographs of the Closed Session materials, or bring recording devices into the Administrative offices, including but not limited to, a camera, cellphone, or other handheld electronic devices. Any materials inspected pursuant to this Section is subject to the confidentiality requirements set forth in this Policy.

VI. CONSEQUENCES OF VIOLATIONS

TCHD is entitled to undertake such actions as are deemed appropriate to ensure that the confidentiality and/or privileged status of documents and information, including a patient's protected health information (PHI), is preserved. If a Director or Committee Member is in doubt about the status of any document or any item of information, the Director shall consult the ~~General~~ Board Counsel for clarification and agree to follow that direction pending consideration by the Board. Any breach of this Policy or threatened breach may subject a Director or Committee Member to disciplinary action, including public censure. Additionally, the improper use or disclosure of PHI may subject a Director or Committee Member to any or all of the civil and criminal penalties specified under HIPAA.

VII. ACKNOWLEDGMENT OF OBLIGATIONS

Each Board and Committee Member shall sign and return to the Board Secretary a copy of the attached Form acknowledging receipt of a copy of this policy and the Notice of Privacy Practice, and agreement thereto, immediately following initial assumption of office and following any material change to the policy.

VIII. APPLICABILITY OF LAW

This Policy and its implementation are subject to applicable state and federal laws relating to the privacy, confidentiality and/or privileged status of any District documents and information, including a patient's protected health information. Violations of this confidentiality policy may be addressed by the District by the use of such remedies as are currently available by State and Federal laws, including but not limited to, Government Code section 54963.

FORM

Tri-City Healthcare District
Confidentiality Acknowledgement and Agreement

PRINT NAME _____

OFFICE/COMMITTEE: _____

I hereby acknowledge receipt of a copy of Tri-City Healthcare District Board Policy ~~10~~17-022 "Maintenance of Confidentiality by Directors and Committee Members" and of the Notice of Privacy Practice, and agree to abide by the terms and conditions of these policies, and the laws they summarize.

1. I understand that I may have personal liability for the release to unauthorized persons of any confidential patient medical information, personnel information, medical quality and peer review, and District trade secret information ("confidential information") to which I am given access as a result of my membership on the Board or on a Committee.

2. I agree to keep secure all confidential information I receive as a result of my affiliation with the District. I also agree that after it is no longer needed, I will return all confidential information to the District for proper disposal or destruction, or I will securely dispose of or destroy it by shredding or equivalent means, whether the confidential information is in paper, electronic or other form.

3. I understand that my obligation to maintain confidentiality under these policies continues after termination of my affiliation with the District.

_____ _____

Signature Date signed

Reviewed by the Gov/Leg Committee: 8/10/05
Approved by the Board of Directors: 9/22/05
Reviewed by the Gov/Leg Committee: 11/8/06
Approved by the Board of Directors: 12/14/06
Reviewed by the Gov/Leg Committee: 10/10/07
Approved by the Board of Directors: 12/13/07
Reviewed by the Gov/Leg Committee: 12/01/10
Approved by the Board of Directors: 12/16/10
Reviewed by the Gov/Leg Committee: 10/12/11
Approved by the Board of Directors: 10/27/11
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 11/7/17
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~16~~17-023

POLICY TITLE: Responsibility for Decision-making on Legal Matters

1. ROLE OF THE BOARD OF DIRECTORS

While the Board of Directors retains ultimate responsibility for the conduct of the business of the Tri-City Healthcare District, the Board has delegated implementation of its policies and day-to-day operations to the Chief Executive Officer (CEO) and management of the compliance program to the Chief Compliance Officer. Notwithstanding these general delegations or other Board policies, the Board of Directors retains responsibility for making the following decisions:

a. ~~General~~ **Board Counsel**. Hiring of ~~General~~ Board Counsel to advise the Board on any legal matter as requested by the Board or as established by policy. The Board shall approve the retainer agreement, provided that the CEO ~~or Chief Compliance Officer~~ may negotiate rates~~, and approve attorneys to be assigned to legal matters over which they have authority, if not otherwise specified in the retainer agreement.~~ Invoices shall be approved by the Chair of the Board.

~~b.~~ **Chief Compliance Officer**. General oversight of the ~~activities of the Chief Compliance Officer in~~ implementation of compliance programs~~, and approval of the job description for the Chief Compliance Officer.~~

~~c.~~b. **Outside Counsel**. ~~Authorizing the retention of any outside lawyer or law firm to represent the interests of the District and approving the terms, conditions and scope of such retention. However, the General Counsel or Chief Compliance Officer, in consultation with the CEO as appropriate, may assign such approved counsel matters, as needed, provided such matters are within the scope of work described in the retainer agreement. The General Counsel or Chief Compliance Officer shall require a matter budget for each new engagement assigned which is expected to exceed $30,000 in fees and costs. In addition, the Risk Manager, in consultation with General Counsel and the Chief Compliance Officer, shall develop and provide outside counsel with written litigation management guidelines that shall apply to all such counsel.~~ The Board shall be provided with information on at least a quarterly basis regarding all matters projected to exceed a total of $50,000 in legal fees, costs, and damages (if applicable).

~~d.~~c. **Claims and Settlements**. With the exception of appeals of the denial of payment for clinical services, the Board shall approve or authorize the settlement of any legal matter exceeding $50,000 in value, whether in favor of or against the District. The Board shall authorize or approve the compromise of any claim made by the District in any litigation or other adversarial proceeding exceeding $50,000, and shall approve settlements exceeding $50,000.

~~e.~~d. **Initiation of litigation**. With the exception of appeals of the denial of payment for clinical services, authorizing initiation of formal arbitration or litigation shall require approval of the Board. However, in the event legal action must be taken to protect life, health or safety within or about the facilities operated by the District, the CEO, with the concurrence of the ~~General~~ Board Counsel or Chief Compliance Officer may approve the commencement of litigation seeking equitable relief. In such event, the Board shall be notified within 24 hours, and ratification of the action shall be placed on the next agenda for consideration by the Board.

B. ROLE OF ~~GENERAL~~ BOARD COUNSEL

See Appendix A.

~~C. ROLE OF CHIEF COMPLIANCE OFFICER~~

~~See Appendix B.~~

Approved by the Board of Directors: 1/30/14
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by the Gov/Leg Committee: 5/06/14
Approved by the Board of Directors: 5/29/14
Reviewed by the Gov/Leg Committee: 6/07/16
Approved by the Board of Directors: 6/30/16
Reviewed by the Gov/Leg Committee: 11/7/17
Approved by the Board of Directors:

Appendix A

Position Description
~~General~~ Board Counsel
Tri-City Healthcare District

Summary: ~~General~~ Board Counsel is retained by and reports to the Board of Directors. ~~General~~ Board Counsel carries out legal duties as assigned by the Board, General Counsel, and the Chief Executive Officer acting within his or her delegated authority. ~~General Counsel supports and coordinates with the Chief Compliance Officer and in-house risk management and legal staff.~~ ~~General~~ Board Counsel advises the District on compliance with state transparency laws, including but not limited to open meetings, public records and conflict of interest laws, as well as compliance with the Local Healthcare District Law.

Essential Functions:

(a) Advises the Board of Directors and District officers in all matters of law pertaining to their offices, upon request and consistent with District policies.
(b) Advises the District on the following subjects: (1) compliance with the Brown Act and related open meeting laws; (2) compliance with Public Records Requests (including risk management program materials) and other records requests referred by District staff; (3) compliance with conflict of interest laws under California law, such as the Political Reform Act; (4) compliance with the Local Health Care District law in operations and financial transactions (to be identified and requested of by General Counsel or Board Chair); (5) compliance with public works contracting rules, including competitive bidding statutes and prevailing wage laws; (6) compliance with Government Claims Act presentation requirements as respects claims against the District, as needed by General Counsel; (7) compliance with the California Voting Right Act; (8) completion of the Local Agency Formation Commission reorganization process.
(b) ~~Represents and appears for the District and any District officer in actions and proceedings in which the District or any officer or employee, in or by reason of his or her official capacity is concerned or is a party, when so directed by the Board, Chief Executive Officer, Chief Compliance Officer or Chair of the Board, as authorized.~~
~~(c) Advises on the initiation of any litigation, and provides, assists or supports the Chief Compliance Officer in, the oversight of litigation matters.~~
(d) Attends ~~all~~ regular and special meetings of the Board of Directors, and such meetings of Board committees, or other meetings as requested by the chairperson of the committee~~,~~or the Chief Executive Officer~~. or Chief Compliance Officer~~.
~~(e) Approves the form of contracts prepared by the District, and reviews the form of contracts to be made by the District as are referred by Chief Executive Officer or Chief Compliance Officer.~~
(f) Prepares or reviews any and all proposed ordinances or resolutions for the District and amendments thereto.
(g) Prosecutes or defends claims or actions on behalf of the District as authorized by General Counsel pursuant to District policy.
(h) Devotes such time to the duties of office as may be specified by any ordinance, resolution or policy of the District.

~~(i) Assists in establishing compliance philosophy and guidelines in conjunction with the Chief Compliance Officer~~.

(j) Advises the Board ~~and senior management~~ on proposed and existing legislation affecting the District.

~~Notwithstanding the foregoing, the Board of Directors shall have control of all legal business and proceedings and may employ other attorneys to take charge of any litigation or matter or to assist the General~~ Board ~~Counsel therein.~~

APPENDIX "B"

Position Title: Chief Compliance Officer	Job Code Number: 20020
Department Name/Location: Administration	Department Number(s): 8610
Status (Check one): Exempt __x__ Nonexempt____	Position Reports To: Board of Directors
Management Approval (VP or higher): Board of Directors	Date Approved: May __, 2014
Compensation Approved by: Board of Directors	Date Approved: May ___2014

The position characteristics reflect the most important duties, responsibilities and competencies considered necessary to perform the essential functions of the job in a fully competent manner. They should not be considered as a detailed description of all the work requirements of the position. The characteristics of the position and standards of performance may be changed by the District with or without prior notice based on the needs of the organization. The physical location for this position will be in the District's corporate headquarters at 4002 Vista Way, Oceanside, CA in an office designated by the Board of Directors. In carrying out these responsibilities the incumbent may be assigned resources as needed, for example, use of an administrative assistant and will follow a process designated by the Board of Directors to obtain critical information necessary to carry out duties as required.

Position Summary:

The incumbent serves as the primary contact for the District's Compliance Program. This individual occupies a high level position reporting to the District's Board of Directors, and functions as an independent and objective person who directs and monitors the District's Compliance Program. Key responsibilities include: develops, initiates and ensures that policies and procedures for the operation of the Compliance Program are implemented so that the District maintains compliance with all applicable laws, regulations, standards of conduct and policies. In addition, the incumbent advises the CEO and/or his designee and the Board of Directors and all internal committees on material legal and compliance risks, mitigation and corrective actions.

Major Position Responsibilities:

1. Develop, implement, oversee, monitor and promote the implementation and maintenance of an effective Compliance Program.
1. Provide guidance to the Board of Directors and the District's senior management regarding matters related to compliance.
2. Deliver ongoing reports of Compliance Program activities to the Chief Executive Officer and to the Finance, Audit and Operations Committee.
3. Report on a regular basis (and no less than quarterly) to the Board of Directors on activities, changes to, and progress of, the Compliance Program.

4. Develop, monitor and revise the Compliance Program, including the Code of Conduct and compliance policies and procedures, as needed and based on changes in, and needs of, the District as well as changes in applicable laws and regulations.
5. Develop and coordinate timely educational and training initiatives that focus on the Compliance Program ensuring that Board members and District personnel are educated on compliance matters.
6. Ensure independent contractors and agents of the District are aware of the District's Compliance Program and how it affects the services provided by contractors and agents.
7. Establish, publicize and reinforce effective lines of communication throughout the organization including, reporting mechanisms, and oversee the District's compliance hotline.
8. Create and enforce policies and procedures, in cooperation with Human Resources, the Procurement Department and the Medical Staff Office related to appropriate screening of the District's employees, contractors, vendors, and health care providers against state and federal health care program and agency debarment lists in accordance with District policies and procedures.
9. In cooperation with Human Resources, oversee and monitor the enforcement of compliance obligations and standards through appropriate disciplinary mechanisms.
10. Oversee and implement systems for routine monitoring and auditing reasonably designed to detect violations of the Code of Conduct and applicable laws, regulations and policies.
11. Establish a regular risk assessment process to identify key areas of compliance risk.
12. Conduct timely investigations of identified potential compliance issues and consult with the District's legal counsel, as necessary and appropriate.
13. Designate work groups and task forces needed to carry out investigations or initiatives of the Compliance Program.
14. Develop and implement appropriate and timely corrective action plans to resolve risks and prevent similar future risks.
15. Manage other resources, as appropriate, to ensure appropriate legal, compliance and risk program services are provided to the District.

Qualifications:

ESSENTIAL COMPETENCIES, KNOWLEDGE, & EXPERIENCE

16. Knowledge of, and familiarity with, health care provider compliance programs, required.
17. Knowledge of state and federal laws and regulations related to health care providers and, particularly hospitals, including fraud and abuse, reimbursement and accreditation standards.
18. Demonstrated ability to communicate with management and report to boards of directors, required.
19. Knowledge of healthcare risk management, claims management, and loss control, required.
20. Excellent written and oral communication skills, personal initiative, organized and methodical, meticulous documentation and computer skills, prompt and reliable, thorough and consistent, and flexible and adaptable to change, required.

Education:

21. Graduate degree in Healthcare Administration, Business Administration or Juris Doctorate degree from an accredited university, required.

Experience:

22. Minimum 7 years' experience in a health care compliance program, preferably in a hospital setting, with at least 2 years at an executive level, required.

Licenses:

23. If JD, CA Bar membership, required.

Certifications:

24. Certification in Health Care Compliance (CHC) through the Health Care Compliance Association (HCCA), California Hospital Association (CHA) or other recognized Compliance Officer Certification, required

Essential Organizational Behaviors

1. Demonstrates behaviors that are consistent with the District's Mission and Values and those that reflect the "Standards of Service Excellence".

1. Performs job responsibilities in an ethical, compliant manner consistent with the District's values, policies, procedures, and Code of Conduct.

2. Works well with team members toward a common purpose. Reinforces the efforts and goals of the work group. Supports the team's decisions regardless of individual viewpoint.

3. Demonstrates flexibility in schedules and assignments in order to meet the needs of the organization and/or Board of Directors.

4. Utilizes, maintains, and allocates equipment and supplies in a cost-effective and efficient manner. Improves productivity through proper time management.

5. Seeks feedback from customers and team members in order to identify and improve processes and outcomes.

Equal Employment Opportunity

Tri-City Medical Center is committed to the principle of Equal Employment Opportunity for all employees and applicants. It is our policy to ensure that both current and prospective employees are afforded equal employment opportunity without consideration of race, religious creed, color, national origin, nationality, ancestry, age, sex, marital status, sexual orientation, or present or past disability (unless the nature and extent of the disability precludes performance of the essential functions of the job with or without a reasonable accommodation) in accordance with local, state and federal laws.

Americans with Disabilities Act

Applicants as well as employees who are or become disabled must be able to perform the essential job functions either unaided or with reasonable accommodation. The organization shall determine reasonable accommodation on a case-by-case basis in accordance with applicable law.

TRICITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~15~~17-042

POLICY TITLE: Duties of the Board of Directors

The purpose of this policy is to define the primary responsibilities of the Board of Directors as the governing body ultimately responsible for leadership of the organization.

Brief Job Description

The Board establishes the mission, vision, and goals for the organization. The Board is ultimately accountable for the quality of care rendered to its patients by both its medical and professional staffs, for its financial soundness and success, and for strategically planning its future. The Board hires the Chief Executive Officer, and approves the plans and budgets by which the CEO will accomplish the quality, financial and strategic goals of the Board. However, the Board has delegated to the CEO responsibility to run the day-to-day operations of all of the District's business enterprises; hence, the Board does not direct operations. Rather, the Board is responsible for ensuring that strategies developed by management will accomplish key goals, achieve the mission and fulfill the vision, and holding the CEO accountable for implementation of those strategies.

Primary Duties and Responsibilities

Financial.

1. Set objectives. It is the role of the Board of Directors, in cooperation with the Chief Executive Office, to specify key financial objectives which are aligned with Board-determined goals, mission and vision for the organization.

2. Oversee attainment of objectives. Through annual approval of the budget, and the ongoing activities of the Financial Operations and Planning Committee, the Board ensures that necessary financial planning activities are undertaken so that the organization's resources are effectively allocated across competing uses. The Board monitors and assesses the financial performance of the organization on an ongoing basis through review of periodic financial statements and other reports prepared and presented by the Chief Financial Officer.

3. Ensure transparency and accountability. Through the selection of independent auditors and acceptance of the annual financial audit report, together with targeted supplemental auditing activities of billing and collection activities for compliance with legal requirements, the Board ensures that appropriate accounting controls are in place and updated, as needed.

Community needs assessment and outreach.

The Board helps keep the organization informed about and sensitive to, community needs and perceptions. Conversely, the Board plays a key role in keeping the community informed regarding the services, activities, and plans of the organization.

Promote quality medical care.

1. Under its Bylaws and those of the Medical Staff, the Board appoints, reappoints and determine privileges of physicians who practice in the institution.

2. The Board hears periodic reports on indicators of quality, utilization and outcomes, as well as quality improvement implementation plans, for each area or department of the organization. The Board holds management accountable to ensure that effective risk management systems are in place and functioning effectively. In this manner, the Board takes responsibility for ensuring the quality of nursing and medical care rendered in the hospital.

3. The Board provides opportunities for members of the medical staff to participate in governance through membership on Board-appointed committees. The Board provides the Chief of the Medical Staff an opportunity to participate in Board meetings, including providing an agenda item at each regular meeting for reports from the Medical Staff.

Compliance oversight.

The Board ensures compliance with requirements of regulatory and accrediting bodies by: (a) promoting an ethical, self-governing culture throughout the organization through Board and employment policies; (b) overseeing the effectiveness of the compliance program; and (c) providing the resources required to implement effective systems.

Responsibilities Defined Elsewhere:

Bylaws.

The Bylaws of the Tri-City Healthcare District Board of Directors set forth, in Article III, the legal powers and duties of the board of directors, as provided under the Healthcare District law. The Board's oversight of compliance activities is reflected in Article VI, §2 (establishing a Compliance and Audit Committee) and Article VII, §3, describing its reporting relationship with the Chief Compliance Officer. Article VIII describes the Board's relationship with the Medical Staff. Article IX, §5 requires the Board to maintain a policy regarding annual self-evaluations.

Board Policies.

Some of the responsibilities of the Board, including those specifically identified by the Joint Commission, are addressed by board policies. The Medical Staff provides input on equipment and services to be provided at the hospital under Policy ~~10~~17-001. Minimum liability insurance requirements required for medical staff membership are described in a policy jointly-adopted by the Medical Staff. (Policy No. _~~10~~15-038.) –The Board oversees the prudent investment of

excess funds under Policy No. _~~10~~14-017, which is reviewed annually. Self-evaluations are conducted by the Board annually under Policy ~~10~~14-012. Board member orientation and training are provided for in Policies ~~10~~16-020 and ~~10~~17-039. Board responsibilities for decision making on legal matters, including hiring ~~General~~ Board Counsel. ~~and the Chief Compliance Officer are~~ is described in Policy ~~14~~17-023. Other policies establish a Code of Conduct for the Board (Policy No. _~~10~~17-039) and committee members (Policy No. _~~10~~15-031), and conflict of interest rules (by resolution in accordance with the Political Reform Act). These are merely examples and are not intended to be a comprehensive list of policies describing Board responsibilities.

Reviewed by Gov/Leg Committee: 1/12/2011
Approved by the Board of Directors: 1/27/2011
Reviewed by the Gov/Leg Committee: 4/01/14
Approved by the Board of Directors: 4/24/14
Reviewed by Gov/Leg Committee: 10/6/2015
Approved by the Board of Directors: 10/30/15
Reviewed by the Gov/Leg Committee: 11/7/17
Approved by the Board of Directors:

TRI-CITY HEALTHCARE DISTRICT
BOARD OF DIRECTORS POLICY

BOARD POLICY #~~15~~17-043

POLICY TITLE: External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms

I. PURPOSE

To set forth limitations, requirements and guidelines for public rental/usage of Tri City Medical Center and other District facilities, including assembly rooms, classrooms, and conference rooms by those external and affiliated organizations, groups and persons which support the public purposes of the District.

II. POLICY

A. **Permitted Uses**. Tri City Medical Center assembly rooms, classrooms, and conference rooms shall be available to those public agencies, nonprofit organizations, associations and other groups, which further the health care needs of the public within the boundaries of the Tri-City Healthcare District, and those directly related to programs and operations which are supported, sponsored by, or affiliated with the District, including meetings of the Medical Staff, and charitable organizations primarily engaged in providing financial or other support to the District.

Although it is a public agency, the use of hospital and other district facilities is dedicated to the provision of health care to the community. By enacting this policy, the District does not intend to create a public forum in its facilities, but only to promote community health and improve health care services delivery within the District.

B. **Compatible Uses**. Public use authorized by this policy shall be solely for meetings and activities which are compatible with the safe, quiet and secure conduct of hospital and health care facility operations, and with the District's status as a public agency of the State of California. For example, several laws prohibit the use of public resources, such as office equipment, staff time, etc., for campaign or personal purposes (e.g., Gov. Code sections 8314, 85300; Penal Code section 426.) Government Code section 54964 restricts an officer or employee of a local agency from expending or authorizing the expenditure of any local agency funds to support or oppose a ballot measure or a candidate. In addition, the following are prohibited:

1. Tobacco use

2. Alcoholic beverages

3. Political or religious activities

4. Amplified sound which can be heard outside of the room being used

5. Commercial uses

6. Personal use by district employees

7. Animals, other than those needed by disabled persons.

C. **Priority of District Use**. The medical, governance, operational, business and emergency needs of the District shall take precedence over other uses of District property in the scheduling and allocation of space under this policy. Scheduled public uses under this policy are subject to cancellation at the discretion of the District. The District will endeavor to provide as much notice as possible..

D. **Liability for Damages/Insurance Coverages**. Groups or persons using District facilities under this policy shall agree to be liable for any personal injury, property damage or liabilities arising out of the conduct of the activity or conduct of the participants. The District may charge the amount necessary to repair damages and/or clean the facility, and may deny the responsible group or person further use of District facilities. Groups engaged in activities posing significant risks to the District may be required to provide evidence of liability, property and professional liability insurance. The Chief Nurse Executive may establish such requirements on a case- by-case basis. Examples of activities which may require evidence of insurance include: professional liability insurance for groups offering free medical screening or other medical services; groups exceeding 100 persons. For activities involving more than 100 persons, the District may require evidence of liability and property insurance.

E. **Rules for Use**

1. No signage or placards will be allowed on District premises without the prior written approval of the District. The District provides standard signage to direct participants to the activity location.

2. Halls, entrances, elevators and stairways will not be obstructed or used for any purpose other than ingress/egress under any circumstances.

3. No furniture, freight or equipment shall be brought in without prior notice, and approval by District.

4. No self-provided food services will be permitted without prior notice and approval by District.

5. Unless otherwise specifically approved, hours of usage will be limited to the hours of 7 a.m. through to 8:30 p.m. Monday through Friday, excluding District holidays. Saturdays may be available at additional cost.

F. **Cause for Denial**. The Chief Nurse Executive (CNE) will review all requests by external and affiliated organizations for meeting room space under this policy. Request for space use may be denied for any of the following reasons:

1. The space requested is not available.

2. The applicant is not among those described in paragraph 1.

3. The applicant has not fully complied with this policy.

4. The use proposed will disrupt the provision of medical care or normal hospital or facility operations, or is otherwise incompatible or prohibited under this policy.

5. The applicant has not provided the evidence of insurance required.

6. The applicant has previously failed to comply with this policy.

III. PROCEDURE

~~A.~~ Applications for usage of assembly rooms, classrooms, and conference rooms are processed via the applicable room scheduler/event coordinator. ~~as described in Exhibit B via e-mail or by telephone.~~

~~B.~~A. The room request form must be completed in full and submitted before applications will be reviewed for compliance with this policy.

~~C.~~B. Unusual~~The~~ room reques~~t form~~ will be forwarded to the CNE for review and ~~approval/~~denial or approval. ~~with conditions.~~

~~D.~~C. The room applicable scheduler/event coordinator will communicate results of request with the applicant.

~~E.~~D. A deposit may be required for any food services or other special services, facilities, setup or equipment to be provided by the District.

~~F.~~E. The District shall be given 48 hours advance notice of cancellation by a successful applicant~~,~~. A~~or a~~ cancellation fee will be charged for any costs incurred by the District prior to the cancelation~~.~~

~~G.~~F. If the District's needs require cancellation of the planned use by an applicant, advance notice shall be given promptly and the deposit refunded.

~~H.~~G. If an application is denied, an applicant may appeal to the Chief Executive Officer.

~~I.~~H. The Chief Financial Officer of the District shall establish a schedule of fees and charges, from time to time, based upon the District's reasonably estimated costs for providing services, including but not limited to: Custodial services; room

setup; food services; equipment rental. Supplemental charges may also be incurred to cover any unusual staff time or legal expenses which may be incurred in reviewing, processing or accommodating a request. The CNE may request supplemental charges, in addition to the payment of scheduled fees and charges. A copy of the Fee schedule and the Meeting Room Request Form shall be provided and appended to this policy as Exhibits A and B.

~~J.~~I. Other than the hourly room rental fee, groups not charging any fee for participation and those not requiring any special services shall not be charged a fee solely for room use.

~~K.~~J. Applicant shall be invoiced by the District on a monthly basis for room rental fees incurred.

IV. ATTACHMENT(S)

A. Exhibit A: Fee Schedule

B. Exhibit B: Meeting Room Request Form

Reviewed by the Gov/Leg Committee: 4/11
Approved by the Board of Directors: 4/11
Reviewed by the Gov/Leg Committee: 4/14
Approved by the Board of Directors: 4/14
Reviewed by the Gov/Leg Committee: 7/15
Approved by the Board of Directors: 7/15
Reviewed by the Gov/Leg Committee: 10/17
~~Approved by the Board of Directors:~~
Reviewed by the Gov/Leg Committee: 11/17
Approved by the Board of Directors:

EXHIBIT A

FEE SCHEDULE

Organizations/groups will not be charged room rental fees if they are 1) a non profit with proper proof of such status; and 2) a health-related program intended to further the healthcare needs of the community; and 3) a service fee of $25 per use to cover basic setup, utilities, custodial services, etc., is paid in advance. Any organizations/groups that do not meet all three of these criteria will be charged the below room rental rates in addition to catering, equipment, and any other fees for additional requests.

ROOM TYPE	*HOURLY RATE*
Classroom	*$30*
French Room	*$30*
Assembly Room	*$50*

These fees are for room rental only and are based on total time utilization for the hours reserved. Should the event exceed the hours requested, the user will be billed for the additional time used in hourly increments. Should an event end earlier than reserved, user will not be entitled to a refund of fees paid. Separate charges will be incurred for custom set-up and break-down, catering, equipment, etc. TCHD retains the right to adjust the rental charges when assessing fees for unusual situations or requests.

EXHIBIT B

Meeting Room Request Form

Date of Request: _____Requestor: _____

Name of Meeting: _____

Date(s) of Meeting(s): _____

Start Time: _____ End Time:_____

Number Attending: _____

Meeting Organizer/Contact Information: _____

Cost Center_____

Seating Style:

Conference___
U-Shaped___
Theater___
Classroom___
Chevron___
Other (attach schematic) _____

A/V Equipment Needed: _____

Additional Comments: _____

_____

Complete form and forward via email to the appropriate Administrator.

Karren Hertz – Board and Auxiliary room requests
Pamela Alm – Non-Nursing and Foundation room requests
Janet Drury – Nursing and Community room requests
Sarah Plant – Medical Staff room requests

TRI-CITY HEALTHCARE DISTRICT

BYLAWS

Approved ~~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. 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 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.

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.

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. 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, approve and remove 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~~ Board 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~~ Board 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 of The 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~~ Board 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 ~~28th~~ day of ~~September~~, 2017.

James J. Dagostino Date
Chairperson

ATTEST:

Laura E. Mitchell Date
Secretary

I. **MEMBERSHIP**

The Department of Pediatrics consists of physicians who are board certified by the American Board of Pediatrics or are board-eligible; having completed an ACGME approved residency in Pediatrics, and who are actively progressing towards certification. Pediatricians who admit and care for neonates in the Neonatal Intensive Care Unit (NICU) must be members of the Division of Neonatology.

II. **FUNCTIONS**

The general functions of the Department of Pediatrics shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee (MEC) guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions, and;
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/ or request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation (OPPE) indicators and formulate thresholds; and
   Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

III. **DEPARTMENT MEETINGS;**

The Department of Pediatrics meets quarterly and no less than three (3) times per year or at the discretion of the Chair

Twenty-five percent (25%) of the Active Department members, but not less than five (5) members, shall constitute a quorum at any meeting.

IV. **DEPARTMENT OFFICERS**

A. The Department shall have 3 officers: a Chairperson, a Vice-Chairperson, and a Quality Review Representative. The officers must be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department. The Vice-Chairperson shall be the Chairperson-Elect and may also serve as the Quality Review Representative.

B. The Chairperson and Vice-Chairperson shall be elected every two years by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department. The notice for elections is given at least one month prior to the meeting date.

C. The Department Chair shall serve a ~~one~~two-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses Medical Staff membership or clinical privileges in the department. Department officers shall be eligible to succeed themselves if elected.

D. The Vice-Chairperson succeeds the Chairperson after his/her term has expired unless there is an objection by a majority of the Active members of the Department who are eligible to vote.

E. The Quality Review Representative serves a ~~one~~two-year term and is elected by the Active members of the Department who are eligible to vote. The Quality Review Representative serves as the Chair of the Pediatric Quality Review Committee (QRC), and attends Medical Staff QA/PI/PSC meetings. Every effort will be made to appoint members to the QRC from each major group and a representative from the unassigned call panel for ED.

V. DUTIES OF THE DEPARTMENT CHAIR

A. The Department Chair shall assume the following responsibilities:

1. Be accountable for the professional and administrative activities of the Department;
2. Ongoing monitoring of the professional performance of all individuals who have delineated clinical privileges in the Department.
3. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
4. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
5. Recommend clinical privileges for each member of the Department;
6. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
7. Other duties, as recommended from the Medical Executive Committee.

VI. PRIVILEGES

A. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the Medical Staff Office.

B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

C. Requests for privileges in the Department of Pediatrics are evaluated based on the practitioner's education, training, experience, demonstrated professional competence and judgment, active clinical performance, documented cases of patient care and are granted based on department specified criteria. Recommendations for privileges are made to the Credentials Committee and to the Medical Executive Committee. Practitioners practice only within the scope of their privileges as defined within these Rules and Regulations.

1. **Nurse Practitioners:** Nurse practitioner means a registered nurse who posseses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care and who has been prepared in a program. The nurse practitioner shall function under standardized procedures or protocols covering the care delivered by the nurse practitioner. The nurse practitioner and his/her supervising physician who shall be a pediatrician will develop the

standardized procedure or the protocols with the approval of the Department of Pediatrics.

D. Classifications of Newborns:

1. Level 1: Newborns greater than 2000 grams and 35 6/7 weeks GA, without any of the diagnoses or symptoms listed in VI (E)(2).
2. Level 2: Newborns needing intermediate or continuing care; criteria as follows:
   i. Weight greater than 2000 grams at birth, r/o sepsis during an observational period, if consistently stable without additional signs of illness.
   ii. Tachypnea, TTN, or other mild respiratory illness, otherwise stable, with oxygen needs <40%, and no oxygen needs over six (6) hours.
   iii. Hypoglycemia (without other risk factors such as suspected sepsis or respiratory distress) with a normal exam and stable vital signs, responsive to oral therapy.
   iv. Feeding problems in a newborn greater than 2000 grams and 35 6/7 weeks gestational age (GA), with no concerns about GI perforation or anomalies.
3. Hyperbilirubinemia requiring phototherapy, unlikely to require an exchange transfusion, otherwise stable, currently 35 6/7 weeks GA and 2000 grams.

If the infant status changes to meet the Level 3 criteria (per NICU unit-specific policy "Admission and Discharge Criteria for the NICU"), a neonatology consult is required. The consultation will be requested by the attending pediatrician who, in collaboration with the neonatologist, will determine if care should be transferred to a neonatologist.

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

A. Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the physician will be required to undergo proctoring for all procedures that were not satisfied. The physician will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VIII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors. ~~An associate may monitor 50% of the required proctoring. Additional cases may be proctored as recommended by the Department Chair.~~ It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued whether the deficiencies noted are based on current clinical competence, practice behavior, or the ability to perform the requested privilege(s). Colleagues who cover on-call for an assigned proctor should be aware, accessible, and amenable to providing proctoring in the place of that member, if needed.

C. For invasive cases, proctor must be present for the procedure for a sufficient period of time to assure himself/herself of the member's competence. For noninvasive cases the proctor may review case documentation (i.e. H&P) entirely to assure himself/herself of the practitioner's competence.

D. In elective cases, arrangements shall be made prior to scheduling i.e., the proctor shall be designated at the time the case is scheduled.
E. The member shall have free choice of suitable consultants and assistants.
F. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
G. A form shall be completed by the proctor and should include comments on diagnosis, procedural technique, and overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the Medical Staff Office.
H. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Office.
I. Members of other departments, such as the Emergency Department or Anesthesiology Department, can proctor an appropriate procedure, but cannot proctor admissions.
J. It is the responsibility of the member to notify a proctor when one is needed.

~~IX. EMERGENCY ROOM COVERAGE~~

~~A. Department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. Refer to Medical Staff Policy and Procedure 8710-520.~~
~~B. Any member who elects to provide follow-up care in his/her office must do so without regard to the patient's ability to pay and must provide a minimum level of care sufficient to respond to the patient's immediate needs.~~
~~C. Provisional or Courtesy Staff may participate on the unassigned call panel at the discretion of the Department chair.~~

~~X.~~IX. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

The Department of Pediatrics will have a Quality Review Committee (QRC) comprised of no less than four (4) Department members. The QRC chair is the Department's representative to the Medical Staff Medical Quality Peer Review Committee. QRC members are able to succeed themselves. The QRC will meet at least four (4) times per year. Refer to Section II "FUNCTIONS" above as applicable.

A. General Function

The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the Department members and to pediatric patients in the hospital.

~~XI.~~X. **NICU M&M COMMITTEE**

The Department of Pediatrics will have an NICU Mortality & Morbidity (M&M) Committee that meets at least quarterly to discuss neonatal cases and issues related to neonatal care. The NICU M&M shall be composed of the members of the Neonatology Division. Representatives from the Department of Obstetrics/Gynecology and nursing shall be invited. The Committee shall maintain a record of its activities and report to the Department of Pediatrics QRC.

APPROVALS:
Department of Pediatrics: 8/~~16~~17
Medical Executive Committee: ~~9/16~~

Medical Staff Pediatrics Rules & Regulations – Revised: 11/03, 05/04, 05/06, 02/07, 07/07, 06/08, 3/09, 5/09, 11/09; 01/10; 5/11; 9/12; 11/12; 5/13; 8/13; 2/14; 6/14; 6/15; 9/16, 8/17

Governance Committee: ~~8/16~~
Board of Directors: ~~9/16~~

I. MEMBERSHIP

A. The Department of Radiology consists of physicians who have a contractual relationship with the hospital to practice Radiology and are board certified or board eligible and actively progressing towards certification in Diagnostic Radiology and/or Nuclear Medicine by the American Board of Radiology.

~~B. The Department of Radiology, at its sole discretion, may also admit physician assistants (PAs) upon a majority vote of the physician members. These PAs must be certified by their certifying body (National Commission on Certification of Physician Assistants (NCCPA)) or be board eligible and achieve such status within two (2) years of appointment. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the Medical Board of California.~~

II. FUNCTIONS OF THE DEPARTMENT

The general functions of the Department of Radiology shall include:

A. Conduct patient care review for the purpose of analyzing and evaluating the quality, safety, and appropriateness of care and treatment provided to patients by members of the Department and develop criteria for use in the evaluation of patient care;

B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the hospital;

C. Conduct, participate in and make recommendations regarding continuing medical education programs pertinent to Department clinical practice;

D. Review and evaluate Department member adherence to:
   1. Medical Staff policies and procedures;
   2. Sound principles of clinical practice.

E. Submit written minutes to the ~~QA/PI/PS~~Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department review and evaluation activities, actions taken thereon, and the results of such actions; and
   2. Recommendations for maintaining and improving the quality and safety of care provided in the hospital.

F. Establish such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring;

G. Take appropriate action when important problems in patient care, patient safety and clinical performance or opportunities to improve patient care are identified;

H. Recommend/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509);

I. Approve On-Going Professional Practice Evaluation Indicators; and

J. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee.

K. Establish protocols for the supervision of Physician Assistants.

III. DEPARTMENT MEETINGS

The Department of Radiology shall meet at least quarterly or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality, safety, and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the ~~QA/PI/PS~~Medical Quality Peer Review Committee, and then to the Medical Executive Committee.

Twenty-five percent (25%) of the Active Department members, exclusive of teleradiology providers, but not less than two (2) members, shall constitute a quorum at any meeting.

IV. DEPARTMENT OFFICERS

The Department shall have a Chair who shall be a member of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the Department.

The Department Chair shall be elected every year by the Active members of the Department who are eligible to vote. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair shall serve a one-year term, which coincides with the Medical Staff year unless he/she resigns, is removed from office, or loses his/her Medical Staff membership or clinical privileges in the Department. Department officers shall be eligible to succeed themselves.

V. DUTIES OF THE DEPARTMENT CHAIR

The Department Chair shall assume the following responsibilities:

A. Be accountable for all professional and administrative activities of the Department;
B. Continue surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;
C. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form;
D. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;
E. Recommend clinical privileges for each member of the Department;
F. Assure that the quality, safety and appropriateness of patient care provided by members of the Department are monitored and evaluated; and
G. Assume other duties as recommended from the Medical Executive Committee.

VI. CLASSIFICATION: Privileges in the Department of Radiology are divided into the following categories:

A. Diagnostic Radiology - Diagnostic radiologists use x-rays, radionuclides, ultrasound, and electromagnetic radiation to diagnose and treat disease. Physicians are eligible for privileges in all routine radiographic and fluoroscopic procedures, and minor procedural components attendant to them as outlined in the Physician Privilege Table. All Diagnostic Radiologists may remotely interpret (teleradiology) diagnostic images.
B. Nuclear Medicine - Specialists in nuclear radiology use the administration of trace amounts of radioactive substances (radionuclides) to provide images and information for making a diagnosis. Members trained and certified only in Nuclear Medicine are eligible for only Nuclear Medicine privileges.
C. Interventional Radiology – Specialists in vascular and interventional radiology diagnoses who treat diseases with use of various radiologic imaging technologies, including fluoroscopy, digital radiography, computed tomography (CT), sonography, and magnetic resonance imaging (MRI). Physicians are eligible for interventional radiology procedures if they meet the credentialing criteria as outlined in the applicable Medical Staff policies/rules (see Interventional Privileges section of the Physician Privilege Table).
D. Teleradiology – Remote interpretation of diagnostic images for emergency, after hours and consultation purposes. Teleradiology only privileges are identified in the Physician Privilege Table.

~~E. Physician Assistants (PA) - A PA may provide medical services that are consistent with his/her education, training, and experience, and PA regulations as outlined in the PA's Delegation of Services Agreement. PAs are also subject to the Allied Health Professional Rules and Regulations. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols as designated in their Delegation of Service Agreement.~~

~~F. Nurse Practitioner (NP) - Nurse practitioners may provide medical services that are consistent with their education, training, and experience, and are outlined in the Standardized Procedures for a NP in the Radiology Department. Nurse practitioners are also subject to the Allied Health Professional Rules and Regulations.~~

VII. PRIVILEGES

A. Request for privileges in the Department of Radiology shall be evaluated on the bases of the member's education, training, experience, demonstrated professional competence and judgement, clinical performance and documented results of patient care and monitoring.

B. All privileges are accessible on the TCMC Intranet and a paper copy is maintained in the ~~Medical Staff Office~~Medical Staff Department.

~~C. By virtue of appointment to the Medical Staff, all physicians are authorized to order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.~~

~~D.~~ C. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.

~~E.~~ D. Sites:

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

~~Physician Privilege Table~~			
~~Privileges~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment (every 2 years)~~
~~Admit patients~~ ~~Consultation, including via telemedicine (F)~~	~~Board certification or board eligible and actively progressing towards certification~~	~~Proctoring satisfied upon completion of proctoring for history and physical examination.~~	~~None~~
~~History and physical examination, including via telemedicine (F)~~		~~Six (6) cases~~	
~~General Diagnostic Radiology and Fluoroscopy~~			
~~Arthrography/arthrocentesis/injection~~ ~~Breast biopsy~~ ~~Computed tomography~~ ~~General diagnostic/fluoroscopy~~ ~~Hysterosalpingography~~ ~~Lumbar or C1-2 puncture/myelography~~ ~~Lymphocintigraphy~~	~~Board certification or board eligible and actively progressing towards certification~~	~~Twenty-five (25) representative blend of cases~~	~~Fifty (50) representative blend of cases~~

Magnetic resonance imaging/spectroscopy Mammography Nuclear medicine (all routine) Positron emission tomography (PET) Radionuclide cysternography and shunt studies Sialography Ultrasonography/hysterosonography Vascular duplex ultrasound Venography			
Special Nuclear Medicine Procedures – Members of the Department trained and board certified only in Nuclear Medicine are eligible for Nuclear Medicine privileges only.			
Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
I-131 therapy for thyroid cancer or for hyperthyroidism Radionuclide therapy low dose < 33 mCi Radionuclide therapy high dose > 33 mCi P-32 intravenous or intracavitary Immune imaging (Zevalin, etc.)	Board certification or board eligible and actively progressing towards certification	Three (3) cases representative blend	Five (5) representative blend of cases
Teleradiology (for Stat-Rad only; all non-Stat-Rad practitioners use General Diagnostic Radiology and Fluoroscopy privileges)			
Computed tomography General radiology General nuclear medicine Magnetic resonance imaging Ultrasonography	25 cases General Radiology and 10 Ultrasound, 10 Tomography, 10 MRI, and 10 Nuclear Medicine	Twenty-five (25) representative blend of cases	Fifty (50) representative blend of cases
Peripheral Vascular Interventional Procedures			
Peripheral angiography (extremity, visceral, thoracic, pulmonary, carotid, cerebral) Peripheral intervention (angioplasty, stent placement, thrombolysis, embolization, drug infusion, stent graft, chemoembolization, etc.) Venography and venous intervention (venous thrombolysis, tPA, stent, IVC filter, venous sampling, transjugular intrahepatic portosystemic shunt (TIPS), venous access procedures (Ports, Midline catheters, Tunneled lines))	Refer to Policy 8710-504	Refer to Policy 8710-504	Refer to Policy 8710-504
Interventional Procedures			
Endovascular AAA repair	Refer to Policy 8710-503	Refer to Policy 8710-503	Refer to Policy 8710-503
Vertebral Augmentation	Refer to Policy 8710-534	Refer to Policy 8710-534	Refer to Policy 8710-534

GI/Biliary Intervention (includes Gastrostomy/Enterostomy, GI Stent, Biliary Drain/Stone removal, Dilation, Stent, etc.	Completed fellowship training in interventional radiology or diagnostic radiology with appropriate experience and acceptable outcomes	Two (2) cases	Twenty (20) representative blend of cases
Genito-Urinary Intervention (includes Nephrostomy, Ureteral Stent, Stone Removal, Tract Dilation, Endopyelotomy, etc.		Two (2) cases	
Biopsy/Drainage Intervention (includes all biopsy, aspiration and drainage procedures		Two (2) cases	
Tumor Ablation Intervention (includes ablation by injection or Radiofrequency probe, Brachytherapy with implantable seeds			
Endovascular (Catheter Based) Therapy for Cerebrovascular Disorders (including: Coil Occlusion of intracranial aneurysms, treatment of AV Malformation or Fistulas)	Refer to Policy 8710-530	Refer to Policy 8710-530	Refer to Policy 8710-530
Pain Management Privileges	Refer to Policy 8710-541		
Sedation Privileges			
Moderate sedation	Refer to Policy 8710-517		
Deep sedation			

Physician Assistant Privilege Table			
General Patient Care Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Perform history and physical examination	Per AHP Rules and Regulations	Ten (10) cases to include therapeutic procedures	Satisfactory evaluation by supervising physician
Furnish drugs consistent with the TCMC formulary and as outlined in the standardized procedures and protocols			
Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication			
General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)			
Recommend therapeutic diets and exercise			
Provide patient education and counseling			
Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation			

Therapeutic Procedures – A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.			
Bone Marrow Biopsy, image guided	Per AHP Rules and Regulations. Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.	Five (5) cases	Satisfactory evaluation by supervising physician
Central line insertion: femoral lines		Three (3) cases	
Central line insertion: PICC lines		Three (3) cases	
Lumbar Puncture, image guided		Three (3) cases	
Paracentesis		Three (3) cases	
Abscess drainage tube manipulation/resuturing		Satisfied upon completion of General Patient Care Privileges proctoring	
Chest tube removal			
Keo feeding tube insertion/nasogastric tube insertion			
Liver biopsy, image guided			
Peripheral IV line insertion			
Removal of drains and/or tubes			
Removal of tunneled catheters			
Removal of venous port (Mediport)			
Subcutaneous local anesthesia			
Suturing and suture removal			
Moderate Sedation	Refer to Policy 8710-517	Refer to Policy 8710-517	Refer to Policy 8710-517

Nurse Practitioner Privilege Table			
General Patient Care Privileges	**Initial Appointment**	**Proctoring**	**Reappointment (every 2 years)**
Perform history and physical examination	Per AHP Rules and Regulations	Ten (10) cases to include therapeutic procedures	Satisfactory evaluation by supervising physician
Furnish drugs consistent with the TCMC formulary and as outlined in the standardized procedures and protocols			
Furnish Schedule II-V controlled substances per the patient specific protocol and per the standardized procedures and protocols. Physician consultation and approval will be obtained prior to furnishing medication			
General evaluation of health status, including but not limited to ordering laboratory procedures, x-rays, respiratory therapy, rehabilitation therapies (physical therapy, occupational therapy, and speech therapy)			
Recommend therapeutic diets and exercise			
Provide patient education and counseling			

~~Refer to physician or specialty clinic when the diagnosis and/or treatment are beyond the scope of the practitioner's knowledge and/or skills, or for those conditions that require consultation~~			
~~**Therapeutic Procedures** – A supervising physician must be physically present in the Radiology Department before therapeutic procedures can be carried out.~~			
~~Central IV access: femoral line insertion~~	~~Per AHP Rules and Regulations.~~ ~~Competency in these procedures will be determined by the Division of Radiology, taking into account training, experience and other post-graduate training.~~	~~Three (3) cases~~	~~Satisfactory evaluation by supervising physician~~
~~Central IV access: PICC line insertion~~		~~Three (3) cases~~	
~~Lumbar Puncture~~		~~Three (3) cases~~	
~~Paracentesis~~		~~Three (3) cases~~	
~~Abscess drainage tube manipulation/resuturing~~		~~Satisfied upon completion of General Patient Care Privileges proctoring~~	
~~Chest tube removal~~			
~~Key feeding tube insertion/nasogastric tube insertion~~			
~~Peripheral IV line insertion~~			
~~Removal of drains and tubes~~			
~~Removal of tunneled catheters~~			
~~Removal of venous port (Mediport)~~			
~~Suturing and suture removal~~			
~~Subcutaneous local anesthesia~~			

VII. REAPPOINTMENT OF CLINICAL PRIVILEGES

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other practice locations may be accepted to fulfill the requirements. If the minimum number of cases is not performed, the practitioner will be required to undergo proctoring for all procedures that were not satisfied. The practitioner will have an option to voluntarily relinquish his/her privileges for the unsatisfied procedure(s).

VII. PROCTORING OF PRIVILEGES

A. Each Medical Staff member granted initial privileges, or Medical Staff member requesting additional privileges shall be evaluated by a proctor as indicated until his or her privilege status is established by a recommendation from the Department Chair to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department will act as proctors.

C. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the proctored member whose proctoring is being continued whether the deficiencies noted are in: a) preoperative, b) operative, c) surgical technique and/or, d) postoperative care.

D. ~~**THE PROCTOR MUST BE PRESENT IN THE PROCEDURE ROOM FOR A SUFFICIENT PERIOD OF TIME TO ASSURE HIMSELF/HERSELF OF THE MEMBER'S COMPETENCE, OR MAY REVIEW THE CASE DOCUMENTATION (I.E., H&P, OP NOTE, OR VIDEO) ENTIRELY TO ASSURE HIMSELF/HERSELF OF THE PRACITIONER'S COMPETENCE.**~~ Supervision of the member by the proctor will include concurrent review for invasive cases or retrospective chart review of cognitive processes for noninvasive cases and direct observation of procedural

techniques. The monitor must be present in the Procedure Room for a sufficient period of time to assure himself/herself of the member's competence.

E. In elective cases, arrangements shall be made prior to scheduling (i.e., the proctor shall be designated at the time the case is scheduled).
F. The member shall have free choice of suitable consultants and assistants. The proctor may assist the member.
G. When the required number of cases has been proctored, the Department Chair must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports.
H. A form shall be completed by the proctor, and should include comments on preoperative workup, diagnosis, preoperative preparation, operative technique, surgical judgment, postoperative care, overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be available from the ~~Medical Staff Office~~Medical Staff Department.
I. The proctor's report shall be confidential and shall be completed and returned to the ~~Medical Staff Office~~Medical Staff Department.

VIII. EMERGENCY DEPARTMENT CALL

Active department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the Medical Staff. The Department Chair will be responsible for maintaining adequate coverage of the Emergency Department. Refer to Medical Staff Policy and Procedure 8710-520.

Provisional or Courtesy staff members may participate on the Emergency Department Call Roster at the discretion of the Chief of the Department.

APPROVALS:

Department of Radiology:	10/7/14
Interdisciplinary Practice Committee:	10/20/14
Medical Executive Committee:	10/27/14
Governance Committee:	11/4/14
Board of Directors:	11/6/14

Audit, Compliance & Ethics Committee
(No meeting held in November, 2017)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

October 26, 2017 – 1:30 o'clock p.m.
Assembly Room 1 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at Tri-City Medical Center, 4002 Vista Way, Oceanside, California at 1:30 p.m. on October 26, 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 RoseMarie V. Reno
Director Larry Schallock

Absent was Director Julie Nygaard

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
Carlos Cruz, 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 Assembly Room 1 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Schallock to approve the agenda as presented. Director Reno seconded the motion.

   Mr. Moser suggested modifying the agenda to move New Business 16 a. into closed session related to the CVRA litigation process.

   The motion on the modified agenda passed (6-0-1) with Director Nygaard absent.

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the October 26, 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 October 26, 2017 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included Conference with Labor Negotiators; four (4) matters of Potential Litigation which include the addition of the CVRA litigation process; Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; one Report Involving Trade Secrets and Approval of Closed Session Minutes and Evaluation of Legal Counsel Services.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Mitchell to go into closed session. The motion passed (6-0-1) with Director Nygaard absent.

6. The Board adjourned to Closed Session at 1:35 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairman Dagostino announced that the Board was back in Open Session.

The following Board members were present:

Director James J. Dagostino, PT, DPT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Julie Nygaard

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
Carlos Cruz, 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 however the Board has requested that an item that was discussed in closed session Labor Negotiations be "trailed" to the open session so the agenda will be reordered slightly to hear this item of discussion first.

10. Director Dagostino led the Pledge of Allegiance.

11. Chairman Dagostino read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 26.

11 a) Consideration of CNA Bargaining Agreement

It was moved by Director Reno that the Board of Directors ratify and accept the CNA agreement as discussed in closed session. Director Grass seconded the motion.

Mr. Steve Dietlin, CEO reported we have been in contract negotiations for a little over a year now with the California Nurses Association and we have reached tentative agreement on all outstanding articles with the nurses and the bargaining units. He stated the contract went to the nurses for consideration of ratification and his understanding is there was an overwhelming vote to ratify and move forward with this contract. He explained the next step is to bring the contract forward to the Board of Directors for consideration and approval as well.

Chairman Schallock stated in his opinion, we should have been able to achieve consensus on the contract in a much shorter period of time, however he wanted to thank everyone for their continued diligence and finally reaching conclusion.

Director Kellett complimented both Administration and the nurses in reaching an agreement. He noted how very important the nurses are and is pleased to have this issue behind us and we are now able to move forward.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

12. Educational Update –

Chairman Dagostino stated the first educational session will be held at the December regular Board meeting in which the California Hospital Association (CHA) will present a webinar to explain how hospitals get reimbursed from different payors.

13. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer reported the Diamond Ball is on the horizon. He stated this year's event will be spectacular with some unique auction items including a "black card" experience with the owner of a prestigious restaurant. Ms. Kimberly Hunt from Channel 10 News will be our Master of Ceremonies and special guest Dana Carvey will be doing a one hour comedy set. Mr. Newhart stated the proceeds of the Diamond Ball will be used to purchase the latest 3D Breast Tomosynthesis & Dimensions 2D Full-Field Digital Mammography system. This system will allow our team to detect breast cancer five millimeters in size or the size of a lentil. He expressed his appreciation to the Board members and hospital for

supporting this event. He noted Tri-City is a major sponsor along with Bob and Sandy Carter who are incredible supporters of the hospital. Mr. Newhart also expressed his appreciation to BMW of Vista, another proud sponsor of the event.

Mr. Newhart reported the Foundation produced a special video that will be played at the Diamond Ball. He expressed his appreciation to Director Dagostino and Mr. Dietlin for participating in the video. Mr. Newhart stated the Women's Center team has gone above and beyond and helped us with filming of grateful patients which included four cancer survivors including a 40 year old woman who was diagnosed with Breast Cancer while she was pregnant.

Chairman Dagostino stated the Board appreciates the Foundation who is our oldest partner, our philanthropic arm.

No action was taken.

14. Report from Chief Executive Officer

Mr. Steve Dietlin, CEO stated Mr. Newhart provided a great recap of coming events and as Chairman Dagostino mentioned the Foundation is a great partner. Mr. Dietlin stated the Foundation is the philanthropic arm of Tri-City and we have many community members that are involved however the Foundation is right there, side by side, raising money for great causes. Mr. Dietlin encouraged everyone to come out and support the Diamond Ball.

Mr. Dietlin stated over 3,300 walkers participated in the inaugural Heart Walk which started at the Oceanside Harbor. 1,200 of those walkers were associated with Tri-City, including our own Chief of Staff and members of the Medical Staff. Mr. Dietlin stated it was a high energy event that raised money for a great cause and he looks forward to doing it again next year and 20 years from now. He expressed his appreciation for everyone's participation.

Mr. Dietlin commented on the CNA contract which is a "win-win" contract that received overwhelming ratification. He expressed his appreciation to the members of the bargaining teams and the nurses for participating and ratifying the contract and for the Board for their support all along the way. Mr. Dietlin stated he is looking forward to moving forward with other hospital business.

Mr. Dietlin stated CFO, Mr. Ray Rivas will be presenting on the first quarter of 2018 financial results. He stated it is a difficult healthcare environment but what you will see is the results are in line with the budget. Mr. Dietlin stated we have multiple partners out there and one of them is our financial partner, HUD. He explained that our clinical partners, financial partners, etc. all need to be working together so we can move forward with important developments like campus redevelopment.

With regard to campus redevelopment, Mr. Dietlin stated we will be starting on phase one which includes a surface parking lot, followed by a parking structure and a new entrance to the hospital.

Lastly, Mr. Dietlin stated the Turkey Trot is coming up on Thanksgiving Day. He reminded everyone to "move your feet before you eat". Mr. Dietlin stated the Turkey Trot draws over 10,000 people and he hopes to see everyone out there.

No action was taken.

15. Reports from Chief Financial Officer

Mr. Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Operating Revenue – $90,053
- Operating Expense – $92,374
- EBITDA – $2,853
- EROE ($1,048)

- Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 172
- Adjusted Patient Days – 28,232
- Surgery Cases – 1,644
- Deliveries – 626
- ED Visits – 15,990

Mr. Rivas also reported on the current month financials as follows: (Dollars in Thousands).

- Operating Revenue – $29,551
- Operating Expense – $30,184
- EBITDA - $1,091
- EROE – ($224)

Mr. Rivas also reported on current month Key Indicators as follows:

- Average Daily Census – 163 vs. 185
- Adjusted Patient Days – 8,886
- Surgery Cases – 565
- Deliveries – 194
- ED Visits – 5,104

Mr. Rivas stated the Average Daily Census number is the result of a patient that was not discharged properly. He explained there were room charges every day that generated a patient day and this went on for approximately 130 days. He stated there was no net revenue associated with that but it did overstate our patient days and we did have to take an adjustment in the current month for the last several months. Mr. Rivas stated the problem was identified and fixed. He stated without this year to date adjustment our Average Daily Census would have been closer to 170.

Mr. Rivas reported on the following indicators for FY18 Average:

- Net Patient Accounts Receivable - $44.9
- Days in Net Accounts Receivable – 48.1

Chairman Dagostino commented on the Average Daily Census and the fact that keeping patients in the hospital is not necessarily good from a financial standpoint. Mr. Rivas agreed and stated that reimbursement varies depending on the payor however there is a big move towards DRG payments which in essence is one payment for a

specific case whether you are here for one day or 22 days. Mr. Rivas stated our monthly average stay is 4, down from 4.5 so we are moving in the right direction.

No action was taken.

16. New Business

b. LAFCO (agenda item to be heard prior to public hearing for clarity)

Board Counsel Adriana Ochoa provided background on LAFCO and the proposed annexations. She stated Resolution 785 which was adopted by the Board directed the Chief Executive Officer to begin the LAFCO (Local Agency Formation Commission) annexation process upon the recommendation of LAFCO. On July 27, 2017, the TCHD Board approved Resolution 787, a Resolution of Application to San Diego Local Agency Formation Commission from the Board of Tri-City Healthcare District for the Annexation of Territory & Amendment of Tri-City Healthcare District's Sphere of Influence. This resolution of application proposes a number of annexations and detachments to change TCHD's current boundaries to be generally more coterminous with the three cities' boundaries.

Ms. Ochoa explained TCHD resolved to move forward with the LAFCO annexations and the CVRA districting process concurrently so that both can be completed in a timely and efficient manner. TCHD believes it is prudent to process the annexations first in order to avoid having to go through the process of drawing election districts twice – saving time, money, and confusion. However, in an abundance of caution, TCHD is proceeding with drawing proposed maps for both scenarios – one contemplating the District's current boundaries, and one contemplating the District's projected boundaries after the annexations are approved. That way, TCHD can assure the public that it will have district-based elections for the November 2018 elections, irrespective of whether or not the LAFCO annexations are finalized before the next election cycle.

TCHD submitted its resolution, application, and processing payment to LAFCO on or about September 25, 2017. LAFCO has informed us that they are finalizing the Preliminary Staff Report for distribution by the end of the month which will start the Assessor/Auditor processing of the proposal. Following the Auditor's report, the Board of Supervisors will process the property tax exchange associated with the proposal. Following the Board approval for the tax exchange, the proposal will be scheduled for a public hearing with LAFCO. There is a 30-day protest/reconsideration period following the Commission's approval, and once that period ends, the proposal will be recorded with the County Recorder. The recordation date will be the effective date of the new boundaries for TCHD.

In terms of timing, Ms. Ochoa explained that LAFCO meets monthly, on the morning of the first Monday. The Commission does not generally meet in January due to the holidays. That would leave February as the likely hearing date for the Tri-City proposal, which would allow for recordation during the first week of March (barring anything unforeseen).

Lastly, if all goes as planned and TCHD's new boundaries are effective in March, the TCHD Board of Directors will have the time and ability to approve maps with the new boundaries for the November 2018 elections. The key issue for scheduling will be how quickly the Board of Supervisors' approval of the property tax exchange can be processed following the Assessor/Auditor.

Director Mitchell questioned if we have selected locations for the community meetings. Ms. Ochoa stated we have proposed facilities for each of the three cities which include the Ruby Showman Auditorium for the City of Carlsbad, the Recreation Center Auditorium in Oceanside (300 North, the Strand) and the Gym Porter Recreation Center in Vista. Ms. Ochoa stated as soon as we get locations solidified and our down payments paid we will update the Board's website.

a. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections – Elections Code §10010(a)(2)

On behalf of the Tri-City Healthcare District, Chairman Dagostino welcomed the public in attendance this afternoon and gave a brief introduction to this California Voting Rights Act public hearing and announced some background and protocol.

Chairman Dagostino stated this public hearing is being held in accordance with Elections Code section 10010(a) (2). The District is changing the way its Board of Directors is elected. Instead of the current at-large method of elections, in which all voters have the opportunity to vote on each open seat, the District Board of Directors will be elected by zones. This change will allow voters to now vote for the one Board member representing the zone where the voter lives once every four years.

The District first published and made available four draft maps and corresponding sequences of elections on October 19, 2017. Each of these maps divides the District into seven different voting zones. Two of these draft maps reflect the current boundaries of the District; two of these draft maps reflect the projected boundaries of the District after certain proposed LAFCO annexations are approved.

Today's public hearing will be the first of five opportunities for members of the public to comment on these draft maps and the sequence of elections. After today, there will be three community meetings held over the next month, one in each of the District's three representative cities. There will be a community meeting to discuss these draft maps in the city of Oceanside on November 29 at 5 p.m., in the city of Carlsbad on November 29 at 7 p.m., and in the city of Vista on November 30 at 5:30 p.m. The next public hearing to discuss these maps and any proposed revisions is scheduled for December 7, 2017, at 3 pm here in this room. For further information regarding locations of these community meetings, please visit the District's website, www.tricitymed.org/zones.

Chairman Dagostino stated first, we will hear from our California Voting Rights Act consultant Justin Levitt of the National Demographics Corporation regarding the four draft maps.

Mr. Justin Levitt, National Demographers stated we are here to present our initial draft maps. He explained we are not going to be asking you to eliminate any particular map but looking at providing comments and feedback that we can take back for the next public hearing, any proposed revisions or changes or any new ideas that you would like to see brought forward at the next hearing. He reiterated that this will create seven zones and each member of the district will reside in one of these seven zones and elect a representative from that zone rather than having an election for all of the members that are up in that year. The first election in this process will be in 2018, the second set of zones will be up in 2020. Mr. Levitt stated we will be looking at maps with and without the border changes. He explained if the name of the map is a fruit that map represents the current boundaries. If the name of the map is a color it represents the new annexed boundaries. We are looking at options that have to meet a set of criteria

including equally populated areas of the seven zones that we draw. Mr. Levitt demonstrated how to use the interactive viewer map which allows you to see in more detail than you could see on a paper map. It allows you to zoom in and zoom out to see different ranges. You can also turn each of the maps on and off and search for an address. The interactive map allows you to compare different maps much more easily.

Mr. Levitt stated we have also looked at proposed election sequencing which is required under AB350. Based on the Health & Safety Code we will have three even zones up in 2018 and four odd zones up in 2020. Mr. Levitt encouraged the public to not only look at what you like and dislike about the maps but also consider the sequencing and if changes need to be made.

Director Schallock questioned if you count the military individuals related to Camp Pendleton who are voters that are registered elsewhere. Ms. Ochoa responded that under the current boundaries that population is included however that is something that the LAFCO annexations are planning to correct.

Director Mitchell stated she does not like the Apple map and its respective numbering. However at first glance she likes the way the Purple map is divided. Director Mitchell stated it would be helpful to have poster size maps available at the community hearings. She also suggested major roads and landmarks be labeled. Ms. Ochoa stated we will do our best to incorporate those revisions into the maps before the community meetings.

Director Grass requested clarification for Board members who were elected in 2016. Ms. Ochoa stated Board members who were elected in 2016 will continue as Board members for all four years, however if you live in the same district as someone whose district is up for re-election in 2018 (because of even and odd number zones) and that person runs and gets the seat, then your district is not going to have an election again until 2022. Your next opportunity to run will be in 2022 instead of 2020. Ms. Ochoa stated that is where sequencing of elections is important. She stated there are seven zones and the Board should think about which zone you want to assign which numbers to in order to best create fluidity and continuity of the Board and to reflect what the voters voted on in 2016.

Director Reno commented that the voters are going to be extremely confused. Ms. Ochoa stated unfortunately it is a very complicated process. She stated we can try and draw the lines to create a continuity of the Board which is in the best interests of the District.

Director Schallock stated that sounds like gerrymandering and he would not be in favor of that. He stated in doing this you are still leaving out Vista. He commented on the importance of having three districts in this first election, one in Oceanside, one in Vista and one in Oceanside and the other zones will likely end up blended. Ms. Ochoa requested confirmation from Director Schallock that for the 2018 election cycle the maps should include one zone in each of the three cities. Director Schallock confirmed that is his opinion.

Director Grass questioned if you could have a combination system where four members would be elected at large. Ms. Ochoa stated as long as there is any at large component it still falls under the California Voting Rights Act as an at large system which can be considered illegal if racially polarized voting is found to exist.

Chairman Dagostino stated this is a hospital board that serves three cities. He questioned in the hybrid forms of districting (some at large and some city based), have there been any suits regarding this. Ms. Ochoa stated she believes Schenkman is focused on districts that are all at large. She stated she has not seen a lawsuit yet that has challenges a combination system. Ms. Ochoa stated it is expressly contemplated under the CA Voting Rights Act. She believes a challenge to one of those systems would be harder than a challenge to an all at large system. Chairman Dagostino stated we want representation from all three cities however this is a unique position and it is important to have the best qualified people to serve on this Board. Chairman Dagostino stated he believes the hybrid system would have the best results.

Director Mitchell questioned if we can expect a radical change in lines when the 2020 census is published. Mr. Levitt stated you will see population growth in some of the more rural areas however he doesn't anticipate a radical change.

Director Reno requested clarification on the LAFCO annexation. Ms. Ochoa stated the Green and Purple maps reflect the annexation. Apple and Pear maps reflect the current boundaries. Ms. Ochoa stated in the next month the Board should begin thinking what two options they like best (a current boundary map and an annexation map).

Chairman Dagostino recognized Ms. Kim Stone, City of Oceanside. She commented that maps were extremely difficult to locate on the District's website. She also questioned if they maps would be bilingual.

Chairman Dagostino recognized Mr. Victor Roy, City of Oceanside. Mr. Roy expressed concern with the back-to-back community meetings on November 29th. He suggested meetings be held on three separate days. Mr. Roy also commented that the Junior Seau Center is a poor choice of venue and suggested we look at the community rooms at the respective libraries. Lastly, Mr. Roy commented on a recent court case related to zone elections.

Chairman Dagostino recognized Mr. Lou Montulli, City of Vista. Mr. Montulli stated his real concern is that Vista has not been represented on this Board for the better part of ten years. He suggested in fairness two zones in Vista be up for election in 2018.

Ms. Ochoa responded to the public's questions/comments.

She demonstrated how to find the maps on the District's website. She stated she will also work with the District's webmaster to see if there is a way to make the maps easier to find.

Poster Boards of maps will be displayed at the community meetings and to the extent possible will show streets and landmarks.

Ms. Ochoa stated she did not know if it would be possible to make maps bilingual.

With regard to the scheduling of the Community Meetings. Ms. Ochoa stated November 29th and 30th are the dates we could get District staff, Counsel and the Demographer together. She stated we anticipate the meetings will last no longer than an hour. However if the Oceanside meeting runs longer we can come back on December 7th and propose another community meeting.

With regard to locations, Ms. Ochoa stated she appreciated the public's input and will look at city libraries and other locations.

Ms. Ochoa stated we are aware of the Poway lawsuit and are tracking it.

With regard to "wiggle room" as to population, Ms. Ochoa stated equal population is mandated within 10% which is 5% over or 5% under in a single zone.

Director Reno stated she continues to be concerned with Vista's representation. Ms. Ochoa stated on December 7th we can bring a few different sequences of elections for consideration. One consideration will be continuity of Board members and one will include electing a member from each of the three cities with other zones blended. Ms. Ochoa stated it will ultimately be up to the Board if two seats are up for election in Vista in 2018.

The public hearing was closed.

c. Consideration to waive Board Policy #14-006 – Board of Directors Meeting Minutes related to waiving of audio or video taping for the three community public hearings.

Chairman Dagostino stated our policy states that all public meetings will be audio taped. Thus if a quorum of the Board is present we would be required by policy to audio record the community meetings at a cost of approximately $1,500. Therefore we would like the Board to consider waiving the audio recording of the three community meetings. Mr. Moser further clarified the community meetings will be considered Board meetings if a quorum of the Board attend.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors waive Board Policy #14-006 – Board of Directors Meeting Minutes related to waiving of audio or video taping for the three community public hearings scheduled for November 29th and November 30th. Director Schallock seconded the motion.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

d. Consideration to approve a Physician Recruitment Agreement with Dr. Malaygiri Aparnath, Pulmonologist and Critical Care Physician

Mr. Jeremy Raimo, Senior Director of Business Development reported Dr. Aparnath is a Board Certified Pulmonary Critical Care physician who is very respected in his current role in the inland valley. Dr. Aparnath wants to be a community based provider for Pulmonary Care and there is a significant need in the community for patients to access pulmonary ambulatory care coupled with his practice in the community. In addition Dr. Aparnath will provide coverage in the ICU. Mr. Raimo stated that Dr. Aparnath brings a new sophistication in terms of what he can do with

ultrasound equipment inside the lung and being able to diagnose different cancerous lesions inside the lung to a biopsy.

Mr. Raimo recommended that the Board consider this two year Physician Recruitment Agreement with Dr. Aparnath.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors find it in the best interest of the public health communities served by the district to approve a Physician Recruitment Agreement with Dr. Malagiri Aparnath, not to exceed $760,000 in order to facilitate this Pulmonary and Critical Care physician practicing medicine in the communities served by the District and recommended by the Finance, Operations & Planning Committee. Director Schallock seconded the motion.

The vote on the motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

e. Discussion regarding 2018 Regular Board Meeting Schedule

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the proposed 2018 Regular Board Meeting schedule. Director Reno seconded the motion.

Discussion was held regarding the fact that in the past the October meeting was omitted due to electioneering that often takes place during election years. It was noted that it is not feasible to go two months (October/November) without a Board meeting.

Director Schallock withdrew his motion. Director Reno withdrew her second to the motion.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors recommend that the proposed 2018 Board Meeting Schedule be amended to omit the October 2018 Regular Meeting and add a meeting to be held on the first Thursday following the November election. Director Reno seconded the motion.

The vote on motion was as follows:

YES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

17 Old Business

a) Update on Board Portal

Director Mitchell stated we are still on track to go live with the Board Portal in December. She emphasized that members of the Board can accept the IPAD or remain on paper. Director Mitchell stated policies will be developed and training provided for all Board members. Director Reno suggested that training and implementation be postponed until early in 2018 due to other pressing meetings.

Director Reno stated when the Professional Affairs Committee material is voluminous it would be helpful to place that material is a separate file so the Board book can be more manageable.

b) Board Retreat Follow-up

1. Board Committee Recommendations regarding committee composition and meeting frequency.

    a. Audit, Compliance & Ethics Committee
    b. Community Healthcare & Alliance Committee
    c. Employee Fiduciary Subcommittee
    d. Governance & Legislative Committee
    e. Human Resources Committee

Chairman Dagostino stated the Board was tasked with streamlining their meetings to be more efficient. As a result, Board Committee Chairs have been asked to re-evaluate their membership and meeting frequency. Chairman Dagostino referred to the committee recommendations contained in today's meeting packet.

Chairman Dagostino stated the Professional Affairs Committee and the Finance Operations & Planning Committee have not had the opportunity to discuss with their respective committees and will bring their recommendations forward next month.

With regard to the Audit, Compliance & Ethics Committee, Director Schallock explained the community membership was reduced so that the community members did not outnumber the Board members. He noted the committee has recommended the option of a subject matter expert who would be a non-voting member but could provide their expertise and be an extra set of eyes to ask questions. Chairman Schallock also explained meetings have been reduced to six per year however the committee reserves the right to call a special meeting if the need arises.

There were no recommended changes to the Community Healthcare & Alliance Committee. It is a unique committee and provides an opportunity for the Board and community to interact and exchange ideas.

Director Kellett stated the Human Resources Committee and Employee Fiduciary Subcommittee are related. It was recommended that those committees meet quarterly on the same time in sequence however the committee reserves the right to call a special meeting if the need arises. Chairman Dagostino commented on the physician component of that committee. Director Reno stated there are three physicians on the committee however rarely do all three attend. She recommended leaving the physician membership as is. Director Kellett indicated he would discuss the physician component at the next committee meeting.

Chairman Dagostino stated the Governance & Legislative Committee has recommended a reduction in community members to two and a reduction in physician membership from three to two. In addition, the committee has recommended they meet on a quarterly basis however reserve the right to call a special meeting if the need arises.

Director Mitchell stated the Professional Affairs Committee will evaluate their structure next month however the volume of material the committee reviews may preclude the committee from meeting less frequently.

Director Reno commented that the name of the Community Healthcare & Alliance Committee is listed incorrectly and should be Community Healthcare & Advisory Committee. Mr. Moser stated the Bylaws reflect the name of the committee as Community Healthcare & Alliance Committee. He stated you can call the committees by any name, however all the committees are advisory in nature, not just the Community Healthcare & Alliance Committee

Director Reno suggested the name of the committee be deferred back to the committee for consideration.

It was moved by Director Kellett that the Tri-City Healthcare District Board of Directors approve the Board Committee Recommendations related to committee composition and meeting frequency as recommended by the committees. Director Mitchell seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

18 Chief of Staff

a. Consideration of October 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 23, 2017.

It was moved by Director Mitchell to approve the October 2017 Credentialing Actions and Reappointments involving the Medical Staff as recommended by the Medical Executive Committee at their meeting on October 23, 2017. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

b. Consideration of Radiology Privilege Card

It was moved by Director Schallock to approve the Radiology Privilege Card as recommended by the Medical Executive Committee at their meeting on October 23 2017. Director Grass seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

20 Consent Calendar

It was moved by Director Kellett to approve the Consent Calendar. Director Schallock seconded the motion.

Ms. Sharon Schultz, CNE requested item 19 4 F (1) Board Policy 15-043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms be pulled and sent back to the committee to accurately reflect the practices that are being followed.

It was moved by Director Kellett to refer Board Policy 15043 – External Organization Usage of Assembly Rooms, Classrooms and Conference Rooms to the Governance & Legislative Committee for clarification. Director Reno seconded the motion.

It was moved by Director Schallock to pull item 19 4) a) HCCA Membership. Director Kellett seconded the motion.

The vote on the main motion minus the items pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

20. Discussion of items pulled from Consent Agenda

Director Schallock who pulled item 19 (4) a) HCCA Membership questioned the benefit Board members receive from the subscription. Ms. Donnellan stated certain Board members had expressed an interest in belonging to the organization. Director Reno has consistently been a member of the organization and Director Nygaard and Mitchell have been members at one time. Director Reno commented that she received notification that her membership is expiring and she should like the membership renewed. She also stated that she is willing to share her journals that she receives from HCCA with other Board members. Director Mitchell stated HCCA was inconsistent with their contact with her during her subscription period.

Mr. Carlos Cruz, CCO stated he is a member of HCCA and is certified in Healthcare Compliance as well. He explained, as part of membership you get access to HCCA's portal where you can access information. He recommends those who subscribe to keep their physical address and e-mail addresses current on the website's portal. Ms. Cruz stated he believes HCCA is a valuable tool for Boards, especially with their focus on Boards and their relationship with the compliance program and overall responsibility over the compliance program. Ms. Donnellan stated she will facilitate subscriptions for those Board members who are interested in joining.

It was moved by Director Schallock to move approval of the HCCA Membership at a cost of $250/Board Member for Board members who wish to join the organization. Director Kellett seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass Kellett, Mitchell, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Nygaard**

21 Reports (Discussion by exception only)

22 Legislative Update –

Chairman Dagostino stated he is a member of CHA Governance Forum and recently attended one of their meetings in Sacramento. He explained the Governance Forum is the Trustees' legislative arm for CHA. Chairman Dagostino commented on ballot measures that may be on the horizon including one related to limiting CEO compensation, staffing ratios for Dialysis Centers and one related to hospital budgeting.

Chairman Dagostino reported that CHA President/CEO Duane Dauner is retiring however he will stay on for the next year to transition his replacement, Carmela Coyle who has years of policy, political and practical expertise.

Lastly, Chairman Dagostino reported that ACHD has expressed an interest in running an omnibus bill to amend District law. Chairman Dagostino and Board Counsel drafted a document that included changes the District would like to see amended in District Law which included Board compensation among others. ACHD is in receipt of the document and are "shopping" for an author for the bill.

23 Comments by members of the Public

There were no comments from members of the public.

24 Additional Comments by Chief Executive Officer

25 Board Communications

Director Schallock commented that for a first time event, the American Heart Association walk was extremely well attended and it was good to see so many hospital employees out there supporting the program.

Director Schallock commented that the Turkey Trot is coming up on Thanksgiving Day and is a fun, family event.

Director Schallock reported Saturday is *Drug Take Back Day*. He encouraged everyone to dispose of their unwanted/outdated medications. Director Schallock noted they will not accept liquid medications and those need to be disposed of at home.

Director Reno expressed her appreciation to all those involved in the CNA contract negotiations and for their diligence in reaching a conclusion.

Director Grass reported October 22– 28 is National Champlain Appreciation Week. She encouraged everyone to thank our Chaplains for the spiritual support they provide for our patients and their families.

Director Grass reported November 12-18 is Nurse Practitioner Appreciation Week and encouraged everyone to express their appreciation to the Nurse Practitioners as well.

Lastly, Director Grass reported the month of November is National Hospice Month.

Director Mitchell expressed her appreciation to all parties involved in the CNA contract negotiations; for working through their differences and achieving a mutually acceptable resolution for all those involved.

Director Kellett expressed his appreciation to all those involved in the CNA contract negotiations. He stated that Mr. Dietlin was also very much involved in the negotiation process and should be commended for his efforts.

26 Reports from Chairperson

Chairman Dagostino commented on the history of the Kaiser Healthcare Plan. He stated we have a defined population in our community that needs healthcare and the Kaiser experiment teaches us that we have to look to solutions within ourselves to take care of our people.

27 Hearing no further business, Chairman Dagostino adjourned the meeting to continue closed session at 6:00 p.m.

29 The Board returned to Open Session at 7:42 p.m. with all Board members present with the exception of Director Nygaard.

30 Report from Chairperson on any action taken in Closed Session.

Chairperson Dagostino reported no action was taken in Closed Session.

31 Adjournment

Hearing no further business, Chairman Dagostino adjourned the meeting at 7:42 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

November 2, 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 November 2, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director James J. Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, M.D.
Director Laura Mitchell
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Julie Nygaard

Also present were:

Steve Dietlin, CEO
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 10:00 a.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Approval of agenda.

   It was moved by Director Kellett to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (6-0-0-1) with Director Nygaard absent.

3. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda. There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairman Dagostino made an oral announcement of items listed on the November 2, 2017 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Evaluation of General Counsel Services, one matter of Existing Litigation and Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees.

5. Motion to go into Closed Session

It was moved by Director Schallock to go into Closed Session. Director Kellett seconded the motion. The motion passed (6-0-0-1) with Director Nygaard absent.

6. Chairman Dagostino adjourned the meeting to Closed Session at 10:08 a.m.

7. The Board returned to Open Session at 10:30 a.m. with all Board members present with the exception of Director Nygaard.

   Chairman Dagostino questioned if there was a motion to remove Director Reno from the closed session for discussion of her complaint against the District. There was no motion.

   It was moved by Director Kellett to return to closed session at 10:35 a.m. Director Mitchell seconded the motion. The motion passed (5-1-0-1) with Director Reno voting no and Director Nygaard absent.

8. The Board returned to Open Session at 10:40 a.m. with all Board members present with the exception of Director Nygaard.

   It was moved by Director Grass that the Board remove Director Reno from the closed session for discussion of her complaint against the District to protect the attorney client privilege. Director Kellett seconded the motion. The motion passed (5-1-0-1) with Director Reno voting no and Director Nygaard absent.

   Director Reno left the meeting at 10:40 a.m.

   It was moved by Director Kellett to return to closed session at 10:40 a.m. Director Mitchell seconded the motion. The motion passed (5-0-0-2) with Director Reno and Director Nygaard absent.

9. The Board returned to open session at 3:45 a.m. with all Board members present with the exception of Director Nygaard.

10. Report from Chairperson on any action taken in Closed Session.

    Chairman Dagostino reported no action had been taken in closed session.

11. There being no further business, Chairman Dagostino adjourned the meeting at 3:45 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
November 29, 2017 – 5:00 o'clock p.m.
El Corazon Senior Center
3302 Senior Center Drive
Oceanside, CA 92054

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 3302 Senior Center Drive, Oceanside, CA at 5:00 p.m. on November 29, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, PT, DPT
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent were Director Cyril F. Kellett, M.D. and Director Leigh Anne Grass

Also present were:

Steve Dietlin, CEO
Kapua Conley, COO
Carlos Cruz, CCO
Norma Braun, CHRO
Susan Bond, General Counsel
Adriana Ochoa, Board Counsel
Doug Johnson, Demographer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 5:00 p.m. at the El Corazon Senior Center at 3302 Senior Center Drive, Oceanside, CA with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda.

3. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections – Elections Code 10010(a) (2).

   On behalf of the Tri-City Healthcare District, Board Counsel Adrianna Ochoa welcomed the public in attendance and gave a brief introduction to this California Voting Rights Act community meeting.

   Ms. Ochoa explained that the District is changing the way its Board of Directors is elected. Instead of the current at-large method of elections in which all voters have the opportunity to vote on each open seat, the District Board of Directors will be elected in zones. She stated that this change will allow voters to now vote for the one Board member representing the zone where the voter lives once every four years.

Ms. Ochoa stated today's community meeting is one of three community meetings held by the District, one in each of the District's three representative cities. There will also be community meetings to discuss these draft maps in the City of Carlsbad this evening at 7:00 p.m. and in the City of Vista on November 30th at 5:30 p.m. The next public hearing to discuss these maps and any proposed revisions is scheduled for December 7, 2017 at 3:00 p.m. at Tri-City Medical Center where regular Board meetings are held. Ms. Ochoa stated further information regarding locations of these community meetings can be found on the District's website at www.tricitymed.org/zones.

Ms. Ochoa stated the District first published and made available four draft maps and corresponding sequences of elections on October 19, 2017. Two additional maps were published on November 28, 2017. Each of these maps divides the District into seven different voting zones. Three of these draft maps reflect the current boundaries of the District and three of the draft maps reflect the projected boundaries of the District after certain proposed LAFCO annexations are approved. Ms. Ochoa stated all maps are shown on the poster boards displayed and hard copies are available at the back table. She noted you can also find the maps at www.tricitymed.org/zones as PDF's and use the interactive map viewer on the site that allows you to input addresses to see which district that address falls into in each version of the map.

Ms. Ochoa stated the purpose of today's community meeting is to get your input on these six maps – what you like, what you don't like and if you have a favorite, as well as that other neighborhood considerations make sense for you. She noted both the demographer and Board Counsel are here to answer any questions you might have.

Ms. Ochoa introduced California Voting Rights Act consultant Doug Johnson of the National Demographics Corporation. Mr. Johnson explained there are two sets of maps. The maps with "fruit" names represent the current borders and the maps with "color" names represent the maps that incorporate the LAFCO changes. He stated each zone contains an equal number of people as is required by the California Voting Rights Act. Secondly, lines are drawn to keep neighborhoods and protected classes together, consistent with the California Voting Rights Act. Mr. Johnson explained one set of maps follows the cities borders closely. An attempt was made to follow major roads and rivers and respect communities of interest. He emphasized that the maps presented today are not final. However if you want to change a map you must take an area out so you have equal population areas. Pursuant to California Health & Safety Code Section 32100.04 in 2018 the three even-numbered zones hold elections and in 2020 the four odd-numbered zones hold elections.

At the conclusion of Mr. Johnson's presentation, Ms. Ochoa asked for comments from Board members.

Director Schallock questioned when the Board will begin to narrow down the map selection. Ms. Ochoa stated at the December 7th Public Hearing the Board could, if they so desire, choose two maps to consider (one map with current boundaries and one map with the LAFCO changes). She explained if the Board makes a motion on the map selection, the two maps will be brought back to a future meeting in approximately March (pending LAFCO action by the County Board of Supervisors) to take action on the final map. However, if additional draft maps are drawn revisions must be published seven days before the Board can take any action and two additional public meetings must be held within 45 days.

Director Mitchell questioned the absolute deadline for the Registrar of Voters. Mr. Johnson stated the deadline for the Registrar of Voters is in May.

Hearing no further comments from the Board, Chairman Dagostino opened the meeting to the public.

Ms. Ochoa recognized Ms. Esther Sanchez. Ms. Sanchez stated she is very concerned with the proposed maps as she does not believe the maps are respecting the basic communities. She commented that Oceanside and Vista need more representation. She does not believe the maps are consistent with Article 21 of the Constitution.

Ms. Ochoa recognized Mr. Victor Roy. Mr. Roy requested clarification on the Camp Pendleton area. Ms. Ochoa stated the LAFCO maps modified the jurisdictional boundaries.

Mr. Roy also commented that he is against blended districts and believes it is unfair and could lead to more Carlsbad control. He stated it is important for fair and equal access for all.

Mr. Roy requested clarification on the zones following the 2020 census. Mr. Johnson stated we will be required by law to redraw lines to reflect the 2020 census population.

Ms. Ochoa read a comment from Mr. Michael Odegaard who questioned what is the statistical threshold for protected groups to be significant enough to compel consolidation into one district?

Mr. Johnson stated there is no specific number. He stated that you cannot draw a district that is more than 50% (50% + 1 of citizens of voting age). Mr. Odegaard requested the source of that response. Mr. Johnson referred to a United States Supreme Court decision. He indicated he would provide the case site to Mr. Odegaard following the meeting.

Ms. Ochoa recognized Mr. Ed Martinez who questioned how the top maps were drawn and what factors were used to draw those maps. Mr. Johnson stated the maps were drawn to ensure equal population and keep protected classes together. He noted the Green map follows as close to city borders as is possible. Mr. Johnson stated some prefer the blended map approach because a Board member does not represent a city but rather a district approach. Mr. Martinez stated he does not understand how population influenced the drawing of the maps. Mr. Johnson explained all zones have an equal number of people within 2-3%.

Ms. Ochoa recognized Ms. Sheila Kadah who questioned why Carlsbad is in the District when, in her opinion, the majority of Carlsbad residents go to Scripps for their care. She believes the Board should be comprised of a percentage of those residents who utilize the services of Tri-City. Mr. Johnson stated these are jurisdictional boundaries and the District is based on the tax base that supports the hospital.

Esther Sanchez questioned if we can get information on each city's population and play around with the boundaries. Ms. Ochoa stated that is precisely what the maps reflect. She noted you cannot dilute the Latino vote and zones need to be balanced population wise. He emphasized that equal population "trumps" city boundaries.

Ms. Ochoa recognized Ms. Gwen Sanders who questioned how we are defining the population. Mr. Johnson stated the population is defined by the 2010 census count.

There was extensive discussion regarding Tri-City boundaries versus city limit boundaries. Mr. Johnson reiterated that the boundaries are defined by law.

Ms. Sanchez questioned if the LAFCO application is available for review. Ms. Ochoa stated the Resolution related to the LAFCO application is available on the District's website.

Hearing no further community comments, Ms. Ochoa questioned if Board members had any further comments.

Director Reno stated the Board was advised that the Camp Pendleton would not be included in the population. Ms. Ochoa clarified there are two sets of maps, one set reflects the current boundaries which include Camp Pendleton and the second set reflect proposed annexation/de-annexation LAFCO boundaries.

Hearing no further comments, Ms. Ochoa stated the next public hearing is scheduled for December 7th.

4. There being no further business, Chairman Dagostino adjourned the meeting at 5:56 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
November 29, 2017 – 7:00 o'clock p.m.
Carlsbad City Library – Meeting Room
1775 Dove Lane
Carlsbad, CA 92011

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 1775 Dove Lane, Carlsbad, CA at 7:00 p.m. on November 29, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, PT, DPT
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent were Director Cyril F. Kellett, M.D. and Director Leigh Anne Grass

Also present were:

Steve Dietlin, CEO
Adriana Ochoa, Board Counsel
Susan Bond, General Counsel
Carlos Cruz, CCO
Doug Johnson, Demographer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 7:00 p.m. at the Carlsbad Library at1775 Dove Lane, Carlsbad, CA with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda.

3. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections – Elections Code 10010(a) (2).

   On behalf of the Tri-City Healthcare District, Board Counsel Adrianna Ochoa welcomed the public in attendance. She stated for efficiency we would take comments or questions due to the fact that no new community members are present.

   Chairman Dagostino commented that the Tri-City District Hospital was created in 1959 and the annexation maps are more realistic of boundaries today.

   Director Schallock requested clarification on the incorporated areas. Ms. Ochoa explained that the proposed LAFCO maps capture the Shadowridge and La Costa unincorporated areas. She stated it is not exactly cotenerous because it could cause issues with Palomar and Fallbrook. Ms. Ochoa noted that we recently were advised that Fallbrook Hospital District passed a Resolution supporting our LAFCO application. She

explained that LAFCO is the agency that dictates the formation of local agencies and their boundaries. By law, every five years LAFCO is required to reassess their boundaries and the proposed annexations/de-annexations are the result of that reassessment in 2015.

Mr. Johnson stated a community member does not have to attend one of the meetings to submit their thoughts. He explained how it can be done directly on the District's website. In addition, a community member may e-mail Mr. Johnson or Mc Ochoa directly.

Ms. Rena Marrocco, Vista Resident joined the meeting at 7:15 p.m. She stated she believes that Vista should have more representation. In addition, she believes the representation should be indicative of those who utilize the hospital's services. Ms. Ochoa stated the law requires that the zones have equal population. She noted the Orange map has three potential seats in Vista that include one seat that is "blended". Ms. Marrocco questioned if the community was encouraged to submit maps? Mr. Johnson explained we have encouraged community members to review maps, make comments or suggestions and advised they are free to submit a map of their choice. Mr. Johnson reminded the community that if you suggest changes to a map the zones must still be equal population. He reiterated that changes to maps must be posted seven days prior to discussion.

Ms. Sanchez stated she believes Mr. Schenker who filed the lawsuit is more concerned with proper boundaries than getting the maps done quickly. Director Schallock stated there is a hard deadline by the Registrar of Voters to have a map in place in order to vote by zone in the 2018 election.

Hearing no further questions or comments, Ms. Ochoa stated the next Public Hearing on the matter is scheduled for December 7th at 3:00 p.m.

4. There being no further business, Chairman Dagostino adjourned the meeting at 7:35 p.m.

_____
James J. Dagostino
Chairman

ATTEST:

_____
Laura E. Mitchell
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS
November 30, 2017 – 5:30 o'clock p.m.
Vista Civic Center – Morris B. Vance Meeting Room
200 Civic Center Drive
Vista, CA 92081

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 200 Civic Center Drive, Vista, CA at 5:30 p.m. on November 30, 2017.

The following Directors constituting a quorum of the Board of Directors were present:

Director Jim Dagostino, DPT, PT
Director Laura Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent were Director Cyril F. Kellett, M.D. and Leigh Anne Grass

Also present were:

Steve Dietlin, CEO
Kapua Conley, COO
Susan Bond, General Counsel
David Bennett, CMO
Adriana Ochoa, Board Counsel
Norma Braun, CHRO
Doug Johnson, Demographer
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairman, Director Dagostino, called the meeting to order at 5:30 p.m. at the Vista Civic Center at 200 Civic Center Drive, Vista, CA with attendance as listed above. Director Dagostino led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairman Dagostino read the Public Comments section listed on the Board Agenda.

3. Public Hearing Regarding Draft Maps for Change from At Large to District Based Elections – Elections Code 10010(a) (2).

   On behalf of the Tri-City Healthcare District, Board Counsel Adrianna Ochoa welcomed the public in attendance and gave a brief introduction to this California Voting Rights Act community meeting.

   Ms. Ochoa explained that the District is changing the way its Board of Directors is elected. Instead of the current at-large method of elections in which all voters have the opportunity to vote on each open seat, the District Board of Directors will be elected in zones. She stated that this change will allow voters to now vote for the one Board member representing the zone where the voter lives once every four years.

Ms. Ochoa stated today's community meeting is the last of three community meetings held by the District, one in each of the District's three representative cities. The next public hearing to discuss these maps and any proposed revisions is scheduled for December 7, 2017 at 3:00 p.m. at Tri-City Medical Center where regular Board meetings are held. Ms. Ochoa stated further information regarding locations of these community meetings can be found on the District's website at www.tricitymed.org/zones.

Ms. Ochoa stated the District first published and made available four draft maps and corresponding sequences of elections on October 19, 2017. Two additional maps were published on November 28, 2017. Each of these maps divides the District into seven different voting zones. Three of these draft maps reflect the current boundaries of the District and three of the draft maps reflect the projected boundaries of the District after certain proposed LAFCO annexations are approved. Ms. Ochoa stated all maps are shown on the poster boards displayed and hard copies are available at the back table. She noted you can also find the maps at www.tricitymed.org/zones as PDF's and use the interactive map viewer on the site that allows you to input addresses to see which district that address falls into in each version of the map.

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Ms. Ochoa introduced California Voting Rights Act consultant Doug Johnson of the National Demographics Corporation. Mr. Johnson explained there are two sets of maps. The maps with "fruit" names represent the current borders and the maps with "color" names represent the maps that incorporate the LAFCO changes. He stated each zone contains an equal number of people as is required by the California Voting Rights Act. Secondly, lines are drawn to keep neighborhoods and protected classes together, consistent with the California Voting Rights Act. Mr. Johnson explained one set of maps follows the cities borders closely. He noted the healthcare district borders are not the cities borders. An attempt was made to follow major roads and rivers and respect communities of interest. He emphasized that the maps presented today are not final. However if you want to change a map you must take an area out so you have equal population areas. Mr. Johnson explained how the interactive map works and demonstrated how one might "zoom in" or "zoom out" to see specific street names, roads or landmarks. Mr. Johnson stated pursuant to California Health & Safety Code Section 32100.04 in 2018 the three even-numbered zones will hold elections and in 2020 the four odd-numbered zones will hold elections.

At the conclusion of Mr. Johnson's presentation, Ms. Ochoa asked for comments from Board members and the public.

Ms. Ochoa read the first form submission from the District's website into the record from Kyle Thayer, City of Vista. Mr. Thayer commented as follows: "I would like to speak in favor of the purple plan. This plan allows the most citizens of Vista to have a voice in 2018. This plan also leaves communities naturally intact, whereas the boundaries in the orange plan appear illogical and gerrymandered. I would be disappointed to see the orange plan take effect, but would be happy with the purple or green plan, preferably purple!"

Ms. Ochoa recognized Mr. Lou Montulli. Mr. Montulli stated in the maps that are being presented, you have purposely allowed Carlsbad to elect another Board member in 2018 and Vista would continue to have only one representative. Ms. Ochoa emphasized that

the election sequencing has not been finalized. The focus is on the maps and various zones. She re-emphasized that pursuant to the Health & Safety Code, the even number zones will be up for election in 2018 and the four odd numbered zones will be up for election in 2020.

Mr. Johnson emphasized the maps are not being drawn in an effort to get rid of the existing Board and it is important to preserve the zones where incumbents are up for re-election so the voters can decide who gets elected/re-elected.

Mr. Johnson stated the Green map is mainly city focused. He noted with the Orange map Vista could potentially have four Board members due to the blended zones.

Ms. Ochoa recognized Ms. Cindy Odo-Amen who commented on the Orange map. She questioned who drew the Orange map. Mr. Johnson stated all maps were drawn by his staff.

Director Schallock stated the current boundaries were drawn in the 1950's. He explained the population of Camp Pendleton was included at that time by law however the vast majority of that population is registered to vote in other localities. He stated that LAFCO has recommended we clean up these boundaries to be coterminous with the city's boundaries. Director Nygaard noted city boundaries have also changed over the years.

Mr. Vince Loughney suggested the maps be done in a "jigsaw puzzle" type format in colors so residents can see how their city is divided up. He is concerned that we are asking for input on something that is not visual. Mr. Johnson suggested individuals use the interactive viewer map on the District's website to see how the various layers.

Ms. Ochoa stated the fourth public hearing is scheduled for December 7th at 3:00 p.m. She suggested that the Board consider a cut-off date for maps to be submitted at that meeting. She noted for the Board to consider a new map it must be published seven days before the Board discusses it and there must be two public hearings within 45 days to discuss the proposed new map.

Mr. Montulli suggested the community meetings and public meetings be advertised in other venues to attract more interest. Mr. Johnson stated when the driving force for this change is by an outside attorney, this is standard turnout for these community meetings. Director Reno questioned if these meetings should be noticed in the newspaper. Ms. Ochoa stated the Brown Act requires that the notice be posted on the District's website and at the District offices which is currently being done.

Hearing no further questions or comments, the community meeting was closed.

9. There being no further business, Chairman Dagostino adjourned the meeting at 6:29 p.m.

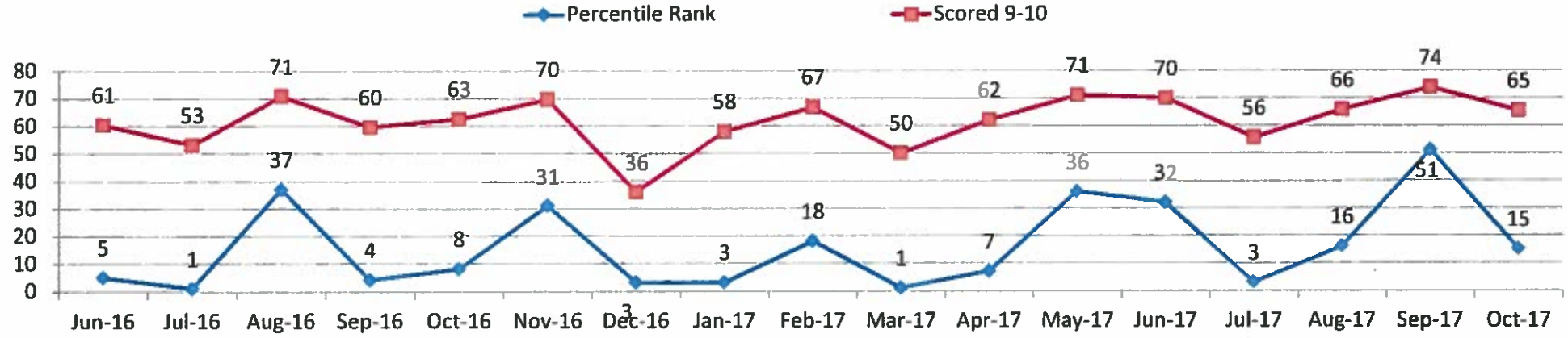
_____
James J. Dagostino
Chairman

ATTEST:

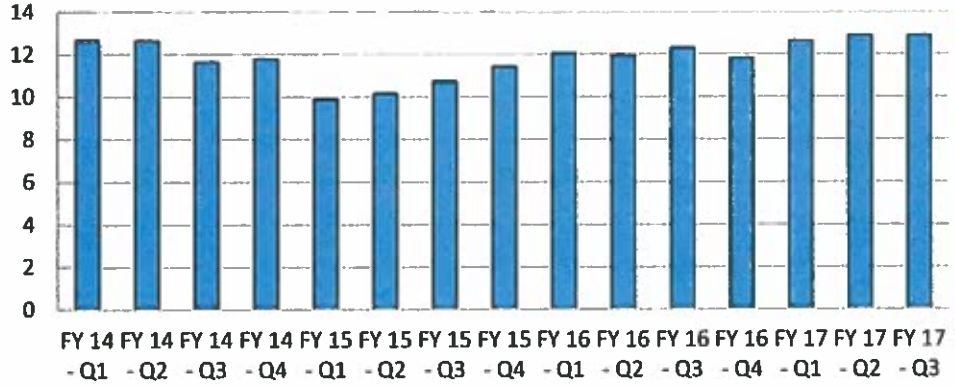
_____
Laura E. Mitchell
Secretary

Stakeholder Experiences

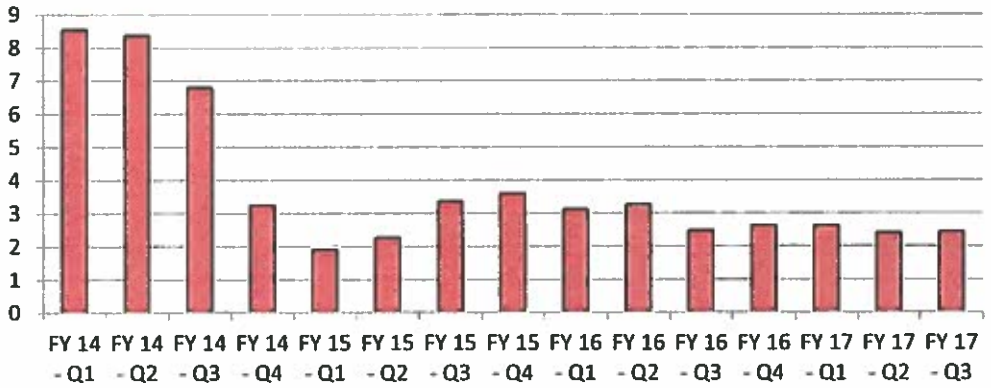
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate

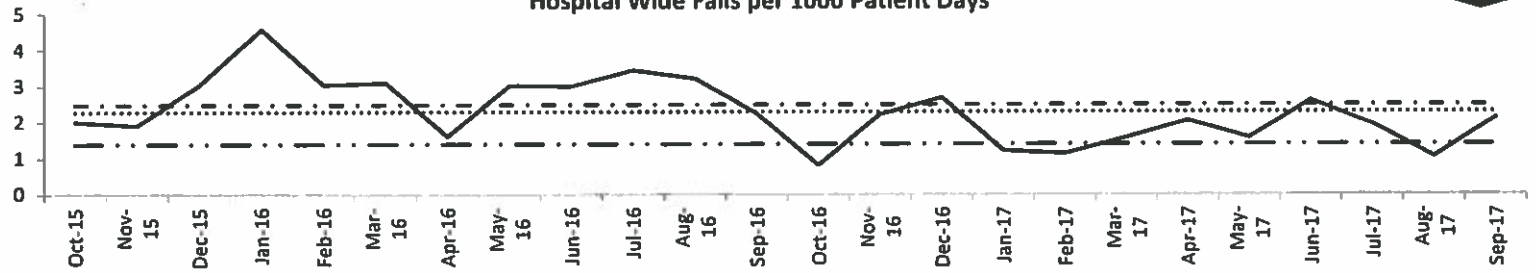


Current Trending Measures

TCMC Rate ..... Mean - · - · - CA Mean — · · — TCMC Target

Better

Hospital Wide Falls per 1000 Patient Days

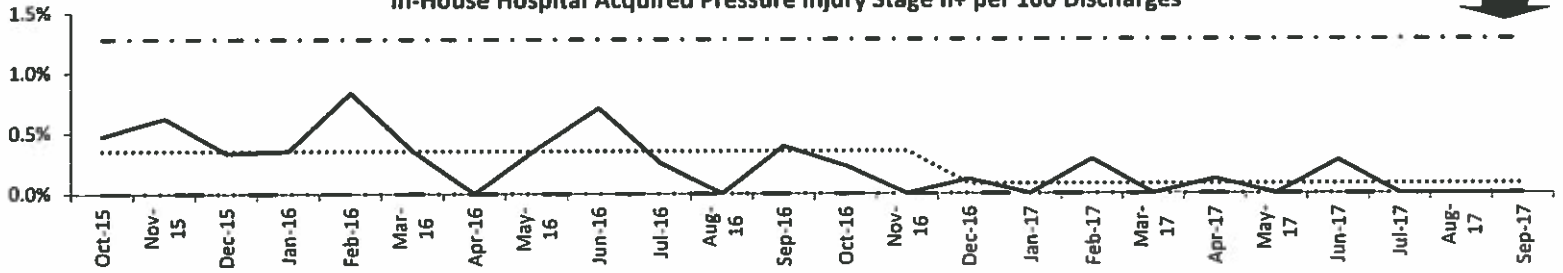


Action Plan

Continued progress due to:
- Assisted Toileting Process
- Redesign of Fall Risk ID
- Pt/Family/RN Partnering Safety Plan
- MsFrench presented at CALNOC conf in Seattle.
- Challenges: Pts don't call: Pts occ left unattended in BR.

Better

In-House Hospital Acquired Pressure Injury Stage II+ per 100 Discharges

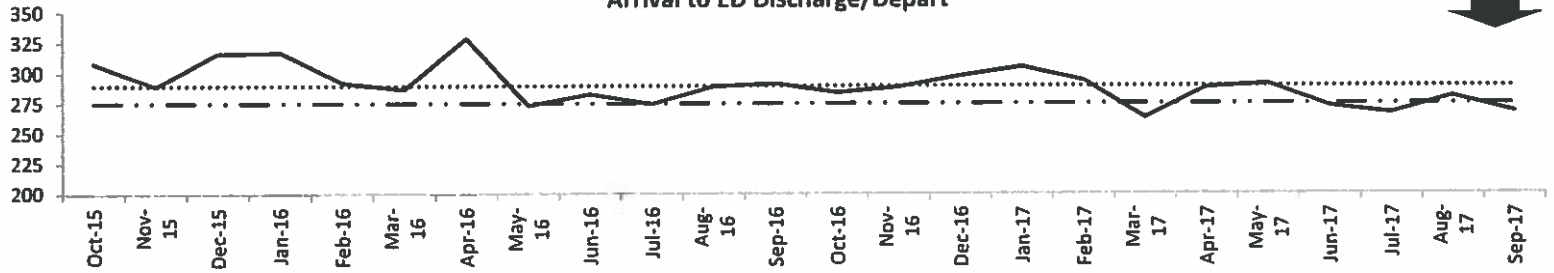


Action Plan

Continue meeting target.
- Implement wound redesign in EMR to improve documentation started 10/17.
- Vascular Injuries differentitated from pressure related injuries

Better

Arrival to ED Discharge/Depart

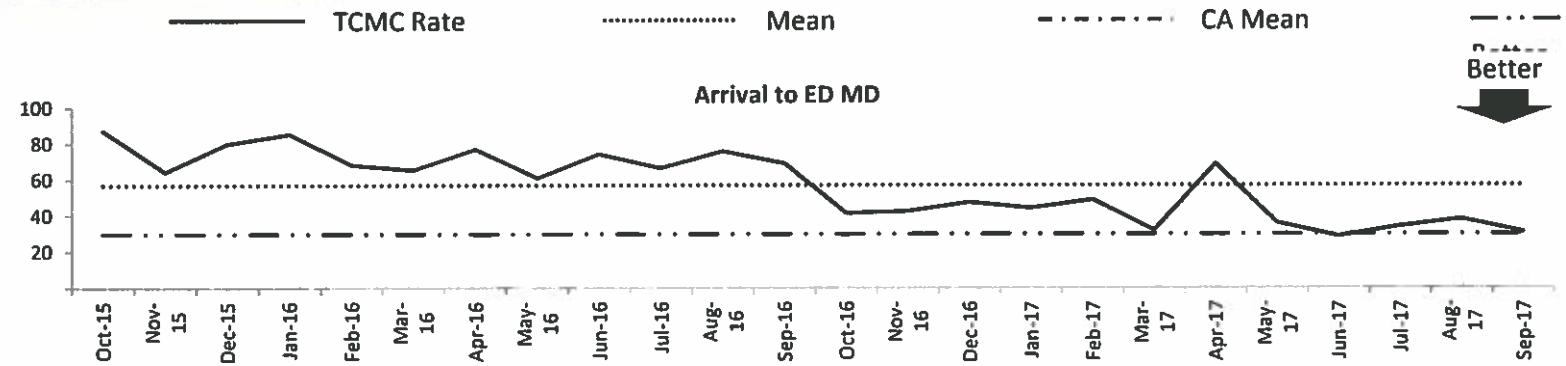


Action Plan

Changes Implemented:
- PA's providing MSE in triage 8a to 2a
- 3/17 Started MD's in triage 10a to MN.

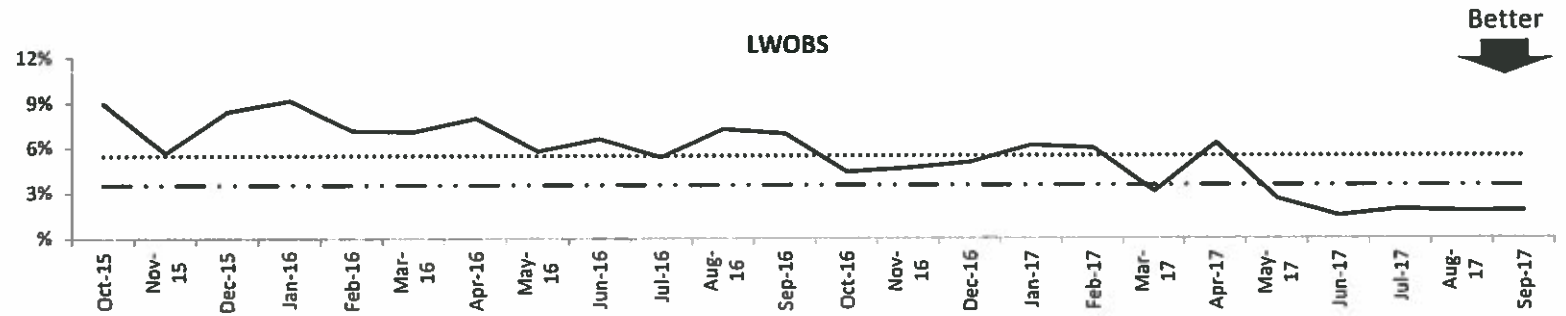
These changes resulted in:
- Decreased LWBS
- Improved patient satisfaction
- HealthStream award for improved Patient Satisfaction score.

Current Trending Measures



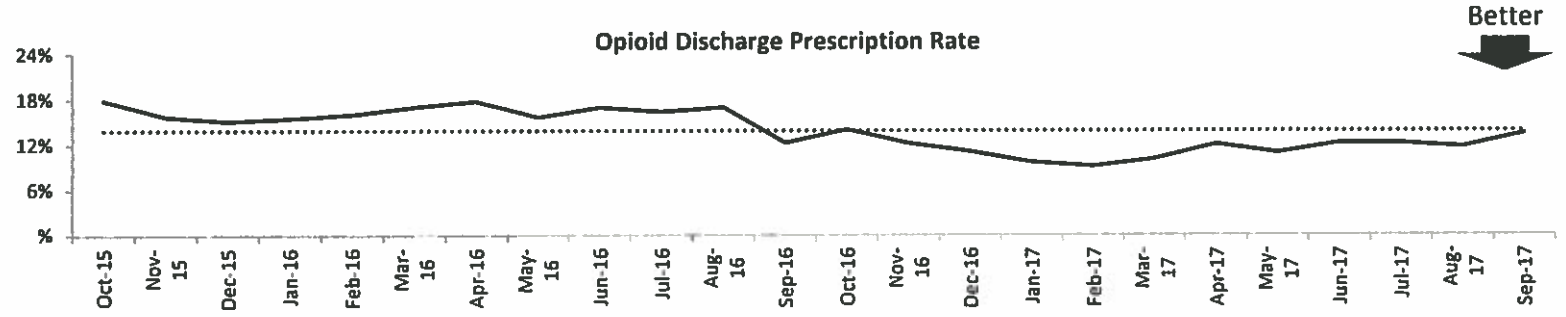
Action Plan

As above
Coming challenge:
- Triage remodel



Action Plan

As above
Goal: 3.5%, 2016 LWBS =6.9%, YTD 2017 =1.16%



Action Plan

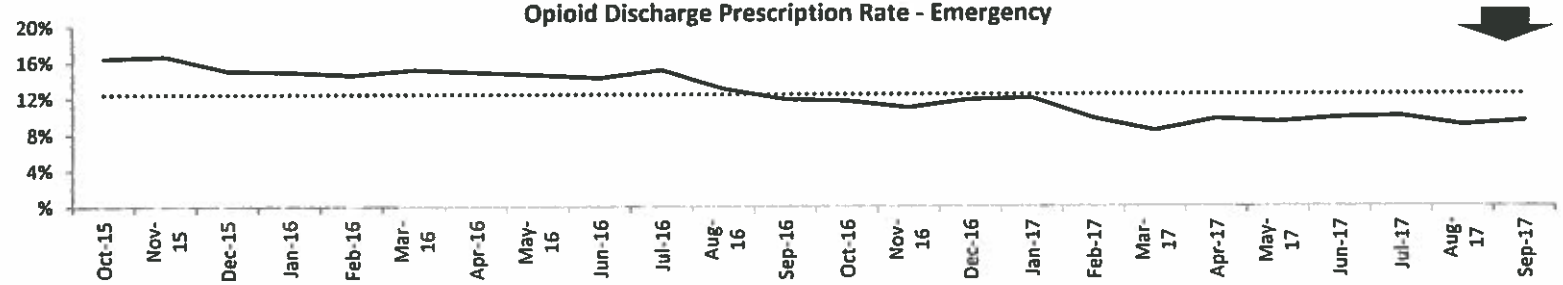
1. Pain management education from the Center for Disease Control was added to the Patient Handbook.
2. Place information in the patient's discharge instruction regarding safe disposal of medications and safe opioid prescription medication usage.

Current ending Measures

TCMC Rate ..... Mean - - - - - CA Mean — · — · — TCMC Target

Opioid Discharge Prescription Rate - Emergency

Better

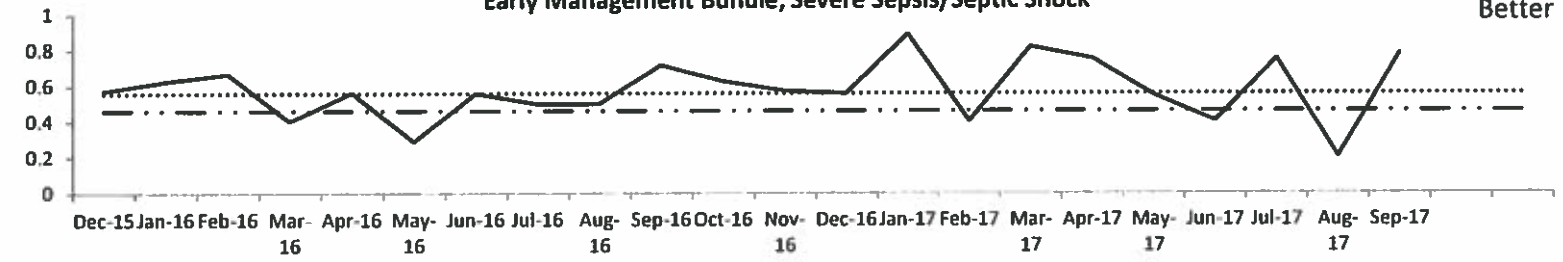


Action Plan

3. Place pamphlets containing the same poster information on all floors for patient and visitor education.
4. Pharmacy and the hospitalists are updating the pain section of the admission power plans used by the hospitalists.

Early Management Bundle, Severe Sepsis/Septic Shock

Better



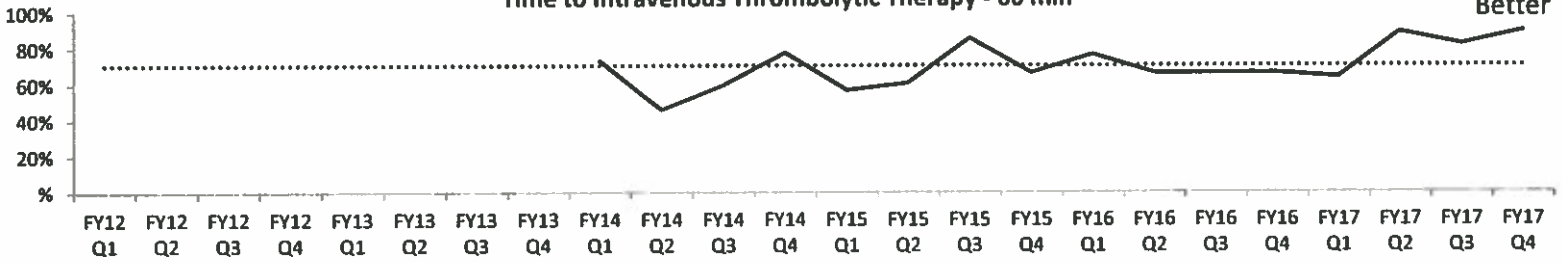
Action Plan

Q3 pass rate 58% is above national avg.
Successes:
- Improved automated proesses for Fluid challenges and lab redraw.
- ED Code Sepsis initiation.

Challenges:
- Septic Shock documentation.
- Post admission onset of Severe Sepsis.

Time to Intravenous Thrombolytic Therapy - 60 min

Better

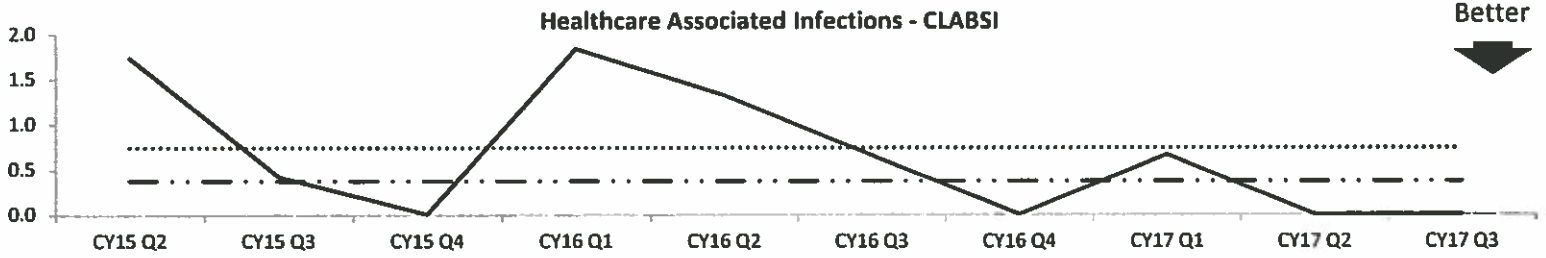


Action Plan

Results continue to improve.
Built drop dow in Cerner for MD's to provide a valid medical reason for a delay.
This removes case from denominator.
100% pass rate for Q3.
Again certified as Gold Plus status with AHA.

Current Trending Measures

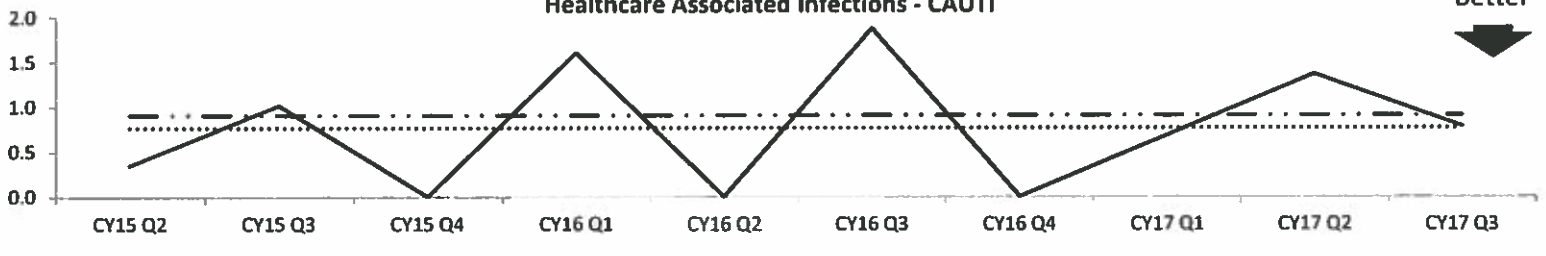
TCMC Rate ..... Mean - · - · - CA Mean — · · — TCMC Target



Action Plan

Summary: CLABSI events 0% for last 2 Qtrs.
Successes:
- Drg changes every Saturday (100%)
- Biopatch & color coded microclaves (99%)
- Swab caps on unused microclaves (95%)
- CAL NOC Achievement Award

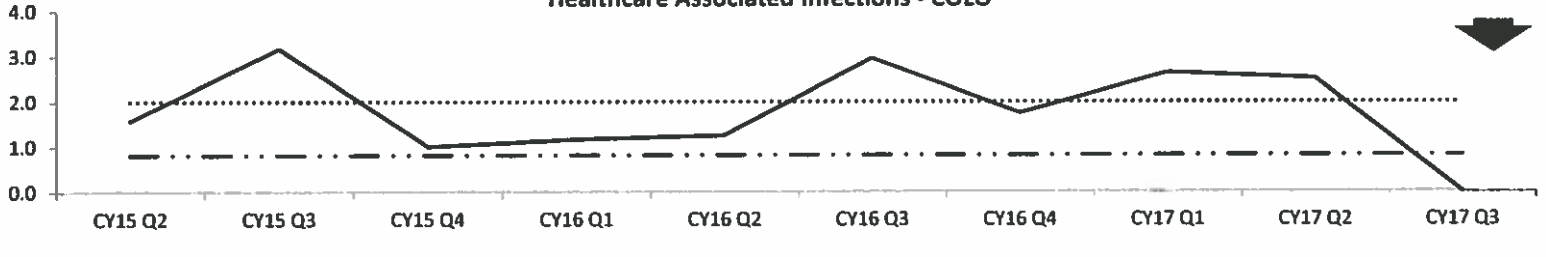
Barriers:
- CHG bath not done daily (50% compliance)
- Disinfection high touch areas (70%)



Action Plan

Summary: For CY2017, CAUTI events below expected.
Successes:
- New male condom catheters

Barriers:
- Timing of urine culture
- Use of alternatives to meas urine output
- Foley catheters in ICU for critically ill patients

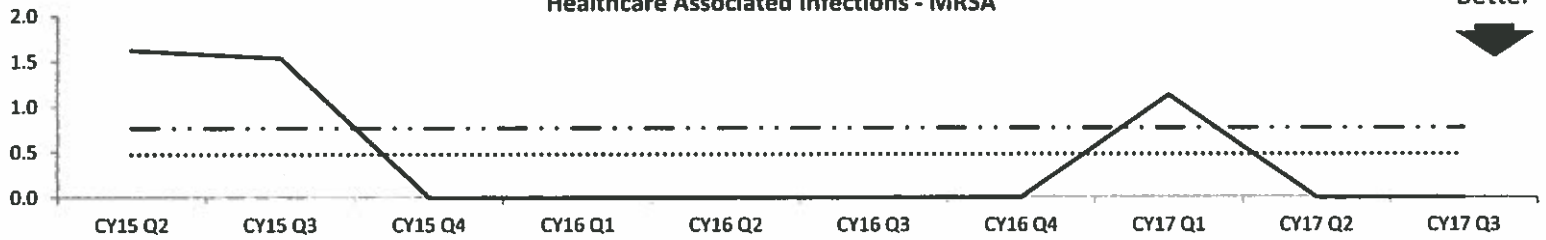


Action Plan

- Returned to using previous dressing.
- Develop standardized post-op drsg changes. Educate to sterile dressing technique.
- Ensure post-op care instructions are clear upon discharge.
- Adv Colorectal surg bundle now used by MD's besides Dr Ghandi.

Current Trending Measures

TCMC Rate Mean CA Mean TCMC Target

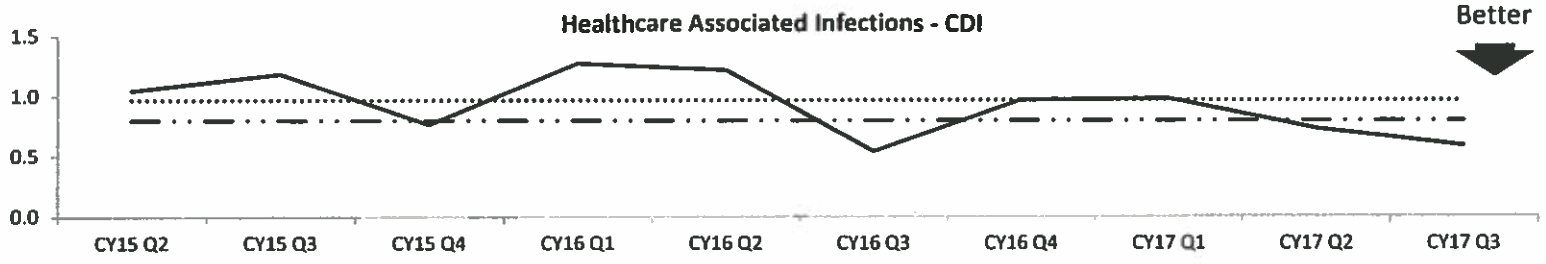


Action Plan

Summary: For CY2017, Lab ID MRSA blood events are below expected

Successes:

Timely identification & testing to identify MRSA present on admission



Action Plan

Successes:

- Hand washing with soap & water

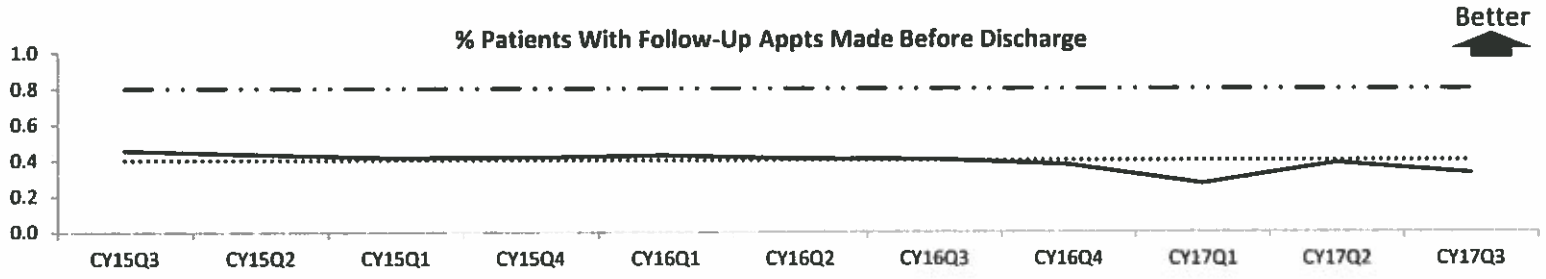
Use of purple D sign

- Disinfection with bleach

Barriers:

- Lack charting stool description to aid in early identification and testing
- Laxative use. Develop Cdiff pathway

Action: Adding Bristol Stool Chart



Action Plan

Diabetic Patients:

- Compliance low since implementation
- Unit secretaries charged with task
- Education ongoing
- Enlisting facilitation from VCC, NCHS
- Tele has chosen this as a performance improvement project

Volume

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	26	23	23	18									72
FY17	28	22	13	25	27	23	19	24	25	25	30	20	281

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	14	6	7	13									27
FY17	9	9	5	13	12	11	10	8	15	8	12	10	122

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11	12	12	14									35
FY17	8	11	8	13	12	8	12	10	12	11	17	21	143

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15	20	20	16									55
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

Performance compared to prior year: Better Same Worse

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	48	37	33	32									118
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	15.7	14.5	16.2	16.3									15.5
FY17	16.5	15.6	15.0	16.2	16.7	16.5	14.4	14.8	16.5	17.5	16.1	16.5	16.0

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	9.0	6.7	6.2	9.5									7.3
FY17	6.8	6.8	6.6	7.0	5.6	6.2	5.6	5.9	4.9	7.0	8.0	9.4	6.7

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	11.3	16.4	12.4	13.9									13.4
FY17	14.8	17.4	17.1	18.6	13.3	17.0	15.5	11.7	10.7	8.8	10.0	11.8	13.9

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	169.7	181.9	163.4	173.4									171.8
FY17	178.6	191.9	181.3	183.9	174.0	179.5	188.0	177.8	174.4	180.5	174.9	168.4	179.5

Performance compared to prior year:	Better	Same	Worse

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	210	222	194	206									626
FY17	223	239	274	230	197	200	217	197	202	172	188	175	2,514

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	12	11	11	11									34
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	4	7	7	3									18
FY17	4	4	6	6	5	7	2	2	7	9	6	1	59

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	8	7	7	11									22
FY17	10	9	8	7	6	9	8	6	16	9	6	6	100

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	YTD
FY18	1.75	1.80	1.81	1.80									1.79
FY17	1.68	1.71	1.76	1.72	1.68	1.70	1.61	1.73	1.73	1.64	1.71	1.76	1.70

Performance compared to prior year: Better | Same | 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	48.9	50.8									48.1	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	46.5	50.0	

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	78.8	83.4									80.0	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	81.9	82.3	

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)	($224)	($171)									($1,048)	($1,187)
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$1,246	

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%	-0.76%	-0.55%									-1.16%	-1.33%
FY17	1.04%	0.75%	2.69%	3.99%	1.51%	1.15%	-0.79%	0.67%	-9.92%	-0.22%	0.99%	5.04%	1.49%	

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	$1,091	$1,146									$2,853	$2,672
FY17	$1,583	$1,496	$2,015	$2,365	$1,711	$1,556	$1,010	$1,428	($1,630)	$1,213	$1,558	$2,741	$5,094	

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%	3.69%	3.66%									3.17%	2.99%
FY17	5.70%	5.32%	7.27%	8.43%	6.27%	5.64%	3.52%	5.28%	-5.55%	4.23%	5.21%	9.16%	6.09%	

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	6.90	6.26									6.42	6.25
FY17	6.04	5.84	5.74	5.85	6.43	6.16	6.26	6.14	6.25	6.30	6.18	6.56	5.88	

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	1.40	1.19									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	1.65	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	$42.3	$48.2									
FY17	$29.1	$29.4	$26.8	$18.9	$23.0	$25.9	$35.7	$34.6	$73.6	$74.3	$77.9	$64.0	

Tri-City Medical Center
MEDICAL STAFF

Applications in Verification Process as of 11-8-17

Last Name	First Name	Degree	Specialty	Application Received Date	Days in Process	Comments
Medical Staff						
Badiee	Behyar	DO	Family Medicine	10/19/2017	14	
Ballas	Jerasimos	MD	Maternal & Fetal Medicine	9/25/2017	26	This file is complete but the providers insurance isn't effective until 1/3/2018. File will be presented at the January Credentials Meeting
Gilson	George	MD	OB/GYN	10/27/2017	8	
Hosseini	Ava	MD	General Surgery	10/13/2017	18	
Malhotra	Kavin	MD	Teleradiology	10/6/2017	23	
Thomas	Steven	MD	Maternal & Fetal Medicine	11/2/2017	4	
Wiseman	Stephen	MD	Anesthesiology	10/13/2017	18	
Allied Health Professionals						
Hunt	Cris	AuD	Audiologist	9/19/2017	35	File is complete and ready to go. Will be presented at the next IDPC meeting
Renne	Brittany	AuD	Audiologist	10/3/2017	26	
Skulsky	Eva	PA-C	Gastroenterology	10/16/2017	17	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending October 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)	10,492.53	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	10/31/17	**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)	10,555.20	09/01/17	08/31/19	**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)	26,047.00	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				$187,619.26			

(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 10/31/17

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	NEUROLOGICAL CHALLENGES	92217	333.95	78147	LINDA SPRAGUE
6183	SURGICAL NURSES ANNUAL CONVENTION	101617	1,597.90	80084	COURTNEY NELSON
7420	AORN VIDEO LIBRARY COURSES	72717	505.00	78238	MARY DIAMOND
8390	CPS ANNUAL MEETING	91117	147.50	79349	TORI HONG
8390	ASHP MED SAFETY MEETING	82917	395.00	81328	THERESA VIDALS
8390	NPPA CONFERENCE	91917	432.94	10894	LAURA BALL
8390	CERNER CONFERENCE	82917	513.78	82547	EVELYN SHEN
8390	CERNER CONFERENCE	82917	523.78	82547	EVELYN SHEN
8390	IHFDA CONFERENCE	60117	1,432.43	81328	THERESA VIDALS
8510	PATIENT EXPERIENCE FORUM	72117	138.89	82728	JENELLE LOVELADY
8510	CERNER CONFERENCE	101817	666.21	82086	RICK SANCHEZ
8610	PRIME LEARNING COLLABORATIVE	100517	357.35	80739	SCOTT LIVINGSTONE
8615	PROJECT MANAGEMENT COURSE	83117	199.00	80986	JAMIE JOHNSON
8620	CHA GOVERNANCE CONFERENCE	101217	336.16	81515	JAMES DAGOSTINO
8650	CA HR CONFERENCE	90717	128.46	81618	FRANCES CARBAJAL
8700	AHIMA CONVENTION	101117	1,075.55	83090	KRISTIN OROZCO
8740	PULMONARY CARE	81717	100.00	12061	NATALIYA BENDETSKAYA
8740	NEONATAL AND ADULT PULOMARY CARE	81717	100.00	13423	ROSIE BOZIN
8740	NEONATAL AND ADULT PULOMARY CARE	81717	100.00	31293	DOREEN GRENUS
8740	SHARP PULMONARY CARE CONFERENCE	81717	100.00	65658	MARGARET STRIMPLE
8740	MGMT OF MEDICATION DURING LACTATION	101317	100.00	78644	CYNDI OZBUN
8740	CONTINUING EDUCATION FOR RADIOLOGY	92817	125.00	82014	MAUREEN O'GRADY
8740	ACLS RENEWAL COURSE	92817	137.47	80037	MELISSA P. MENDOZA
8740	ACLS RENEWAL COURSE	92817	137.47	80038	AMANDA BERGAMINI
8740	NEOMATAL RESUSCITATION PROGRAM	81717	140.00	77564	GAIL HART
8740	ACLS RENEWAL COURSE	100417	140.00	78502	RICHARD HUBER
8740	ASPEN ONLINE SEMINAR	92117	200.00	77946	KELLI GECEWICZ
8740	AABB ANNUAL MEETING	101317	200.00	79260	TERESA ANDREIKA
8740	NEONATAL NURSES CONFERENCE	92817	200.00	81651	KAREN SULLIVAN
8740	ID WEEK CONFERENCE	101317	200.00	82350	MANUEL ESCOBAR
8740	CERNER CONFERENCE	101317	1,255.48	65505	KIMBERLY QUINN
8740	CERNER CONFERENCE	101617	1,281.97	67036	KATHY TOPP
8756	CERNER CONFERENCE	101617	1,167.83	83102	JACLYN HUNTER

**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.