TRI-CITY HEALTHCARE DISTRICT REVISED
AGENDA FOR A REGULAR MEETING
August 30, 2018 – 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) Leonie K Hall v Tri-City Healthcare District Case No. 16-cv-01693-GPC-AGS 2) Delphina Mota and Paul Iheanachor vs. Tri-City Healthcare District, et al Case No. 37-2018-00034758-CU-MM-NC		
	b. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (3 Matters)		
	c. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	d. Approval of prior Closed Session Minutes		
7	Motion to go into Open Session		
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower		

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
	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 – a) National Hospital Organ Donation Campaign – Platinum Recognition for activities to increase enrollment in state registry as organ, eye and tissue donors.	5 min.	CNE
13	Report from TCHD Auxiliary – Mary Gleisberg, President	10 min.	Standard
14	Report from Chief Executive Officer	10 min.	Standard
15	Report from Chief Financial Officer	10 min.	Standard
16	Report from Chief Governmental & External Affairs Officer	10 min.	Standard
17	New Business - None		
18	Old Business – None		
19	Chief of Staff a. Consideration of July Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on August 27, 2018 b. Privilege Card 1) Pediatrics	5 min.	Standard
20	Consideration of Consent Calendar 1) **Administrative & 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.*** 2) **Administrative Committee**	5 min.	Standard

	Agenda Item	Time Allotted	Requestor

a) **Policies & Procedures:**

1) **Patient Care Services Policies & Procedures:**
   a) Admission Criteria Policy
   b) Census Zones, Managing of Policy
   c) Clinical Alarm Management Policy
   d) Code Caleb Response Plan Policy
   e) Latex Sensitivity – Allergy Management Policy
   f) Patient Rights & Responsibilities 302 Policy
   g) Staff Development Education Policy
   h) Staffing, Registry-Traveler Usage Policy

2) **Administrative**
   a) Legal Documents 294 Policy

3) **Behavioral Health Services**
   a) Emergency Medication Policy

4) **Education Department**
   a) Learning Needs Assessment Policy

5) **Infection Control**
   a) Bloodborne Pathogen Exposure Control Plan Policy
   b) Healthcare Associates Infections, Defined IC-4 Policy (DELETE)
   c) IC 5.2 Pregnant Healthcare Workers (Informational Handout)

6) **Lab Gen Lab QA Manual**
   a) Individualized Quality Control Plan Policy

7) **Mammography Women's Center**
   a) Consumer Complaint Mechanism DIT Policy (DELETE)
   b) Enhancing Quality using the Inspection Program (EQUIP) Policy
   c) Health Physicist Testing Policy (DELETE)
   d) Implants Policy
   e) Infection Control Policy (DELETE)
   f) Master Jacket Retrieval & Filing Policy (DELETE)
   g) Personnel Orientation for OPIC Center DIT Policy (DELETE)
   h) Q.C. Policy Phantom Policy (DELETE)
   i) Q.C. Policy – All Policy
   j) Report Inclusions Policy
   k) Retake Repeat Analysis Policy
   l) Standardized Labeling of Mammograms Policy
   m) Training Orientation Competency and Continuing Education DIT Policy (DELETE)

8) **Medical Staff**
   a) Credentialing Policy, Laser & Aesthetic Center 8710-565 (DELETE)
   b) Cultural and Linguistic Proficiency 8710-601
   c) Joint Providership/Co-Providership 8710-602
   d) Medical Record Documentation Requirements 8710-518
   e) Regularly Scheduled Series (RSS) 8710-606
   f) TB Screening of LIPS and Allied Health 8710-538

9) **NICU**
   a) Cleaning and Sanitizing of Specialty Bottles/Nipples (NEW)

10) **Security**

	Agenda Item	Time Allotted	Requestor
	a) Morgue Release (DELETE)		
	11) **Ultrasound Vascular Imaging** a) CideX Protocol for Disinfection Process Policy (DELETE)		
	12) **Women & Newborn Services** a) Nipple Shield and Supplemental Nursing System (DELETE)		
	(3) **Board Committees**		
	A. Community Healthcare Alliance Committee Director Nygaard, Committee Chair *(No meeting held in August, 2018)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(Committee minutes included in Board Agenda packets for informational purposes*		FO&P Comm.
	1) Approval of an agreement with Premier Healthcare Solutions, Inc. for subscription services to Supply Chain Management's Materials Management Information System for a term of 36 months, beginning August 1, 2018 through July 31, 2021, for an annual cost of $171,745 and a total cost for the term of $515,236.		
	2) Approval to add Dr. Jean Paul Abboud to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months beginning September 1, 2018 through August 31, 2019.		
	3) Approval of an agreement with Drs. Andrew Deemer, Adam Fierer, Dhruvil Gnadhi, Karen Hanna, Eric Rypins, Katayoun Toosie, Mohammad Jamshidi-Nezdad as the General Surgery ED-Call Coverage physicians for a term of 12 months, beginning August 1, 2018 through July 31, 2019 at a daily rate of $1,400 for an annual and term cost of $511,700, reimbursement of $725 per case for Unfunded Cholecystectomy and Unfunded Laparoscopic Cholecystectomy with Common Bile Duct Exploration (code 47564: $1,144.51/case and code 47550: $168.05) at an expected cost total cost for these unfunded cases for the term of $32,622.80.		
	4) Approval of an agreement with The Regents of the University of California Team Physicians of Southern California Medical Group, Inc. and Tri-City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 12 months beginning July 1, 2018 through June 30, 2019 for an annual and total term cost of $104,689.56.		
	C. Professional Affairs Committee Director Grass, Committee Chair *(No meeting held in August, 2018)*		PAC
	D. Audit, Compliance & Ethics Committee Director Schallock, Committee Chair Open Community Seats – 0 *(July Committee minutes included in Board Agenda packet*		Audit, Comp. & Ethics Comm.

	Agenda Item	Time Allotted	Requestor
	for informational purposes 1) **Administrative Policies & Procedures**: a) 8750-596 – Identity Theft (Red Flag Rules) (2) Minutes – Approval of: a) Regular Board of Directors Meeting – July 26, 2018 (3) Meetings and Conferences – None (4) Dues and Memberships - None		Standard
21	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
22	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – Included (c) Lease Report – (July, 2018) (d) Reimbursement Disclosure Report – (July, 2018) (e) Seminar/Conference Reports – None	0-5 min.	Standard
23	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually, to address the Board	5-10 minutes	Standard
24	Additional Comments by Chief Executive Officer	5 min.	Standard
25	Board Communications (three minutes per Board member)	18 min.	Standard
26	Report from Chairperson	3 min.	Standard
	Total Time Budgeted for Open Session	2 hours	
27	Oral Announcement of Items to be Discussed During Closed Session		
28	Motion to Return to Closed Session (if needed)		
29	Open Session		
30	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1) – (If Needed)		
31	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 8, 2018

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 8/31/2018 – 7/31/2020)

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 8/31/2018 through 7/31/2020:

- ARRIETA, Iris MD/OB/GYN (Vista Community Clinic)
- BAHARI, Abbas MD/Neurosurgery (cCare)
- BAJA, Jr., Diosdado MD/Anesthesiology (ASMG)
- BERTHELSEN, Steven DPM/Podiatry (Foundation Foot & Ankle)
- EVERSON, Neal DO/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)
- FOSTER, Alexander MD/Ophthalmology (Morris Eye Group)
- JAFFER, Jihad MD/Physical Medicine and Rehabilitation (North County Neurology)
- LIAGHAT, Arash MD/Anesthesiology (ASMG)
- NELSON, Jesse DO/Anesthesiology (ASMG)
- PHAM, Martin MD/Neurosurgery (UCSD)
- RYEL, Justin MD/Emergency Medicine (TeamHealth)

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 7
August 08, 2018

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 9/01/2018 –8/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 9/01/2018 through 8/31/2020, 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:

- **BATRA, Munish, MD/Plastic Surgery/Active Affiliate**
- **BHARNE, Anjali, MD/Medicine/Oncology/Active**
- **BROOKER, Jr., George, DO/Anesthesiology/Active Affiliate**
- **CARR, Kenneth, MD/Medicine/Cardiology/Active**
- **CHATURVEDI, Sanjana, MD/Internal Medicine/Refer and Follow**
- **CHIANG, Pengta, MD/Emergency Medicine/Active**
- **CLANCY, Tara, DO/Internal Medicine/Refer and Follow**
- **CLARK, Ma. Belen, MD/Family Medicine/Refer and Follow**
- **CLARKSON, Chunjai, MD/Obstetrics & Gynecology/Active**
- **COFFLER, Mickey, MD/Reproductive Endocrinology & Infertility/Active**
- **DHILLON-ASHLEY, Tina, MD/Obstetrics & Gynecology/Active**
- **EVTIMOV, Stoimen, MD/Internal Medicine/Active**
- **GABRIEL, Steven, MD/Emergency Medicine/Active**
- **GANDHI, Dhruvil, MD/General and Vascular Surgery/Active**
- **GARNER, Darin, MD/Emergency Medicine/Active**
- **Grove, Jay, MD/General Surgery/Active**

Attachment B

- HERGESHEIMER, Charles, MD/Internal Medicine/Refer and Follow
- HOLMES, Russell, MD/Family Medicine/Active
- ITALIANO, James, MD/Family Medicine/Refer and Follow
- KARANIKKIS, Christos, DO/Obstetrics & Gynecology/Active
- KOKA, Anuradha, MD/Radiation Oncology/Active Affiliate
- KRALL, Peter, MD/Ophthalmology/Active
- LOPEZ, Sandra, MD/Obstetrics & Gynecology/Active
- MCCAMMACK, Bradley, MD/Pediatrics/Active
- MILLER, Jeffrey, MD/Radiology/Active
- MOTADEL, Kelly, MD/Pediatrics/Active
- MOVAHHEDIAN, Hamid, MD/Neonatology/Active
- MURILLO, Maria, MD/Obstetrics & Gynecology/Active
- NGUYEN, Vu, MD/Dermatology/Active
- PARK, Christopher, MD/Radiology/Active Affiliate
- PAZ, Alejandro, MD/Family Medicine/Refer and Follow
- PEEL, Avanee, MD/Teleradiology/Active Affiliate
- PENRY, Jackson, MD/Radiology/Provisional
- PENVOSE-YI, Jan, MD/Obstetrics & Gynecology/Active
- PERKINS, Rachel, MD/Pediatrics/Active
- ROGERS, Christopher, MD/Internal Medicine/Active Affiliate
- SIDDIQUE, Nayyar, MD/Medicine/Oncology/Active
- SOUZA, Victor, MD/Internal Medicine/Active

Attachment B

- **TOOSIE, Katayoun, MD/General and Vascular Surgery/Active**
- **URBANIC, James, MD/Medicine/Radiation Oncology/Active**
- **VIERNES, Matthew, MD/Medicine/Gastroenterology/Active**
- **VRIDHACHALAM, Sanjeevi, MD/Teleradiology/Active Affiliate**
- **WADHWA, Ashish, MD/Otolaryngology/Active Affiliate**
- **WAKEMAN, Gregory, DO/Family Medicine/Refer and Follow**
- **WOLFF, James, MD/Radiology/Active Affiliate**

UPDATE TO PREVIOUS REAPPOINTMENT:

- **HOSALKAR, Harish MD/Orthopedic Surgery/Active**

REINSTATEMENT: (Effective Dates 9/01/2018 –8/31/2020)

Any items of concern will be "red" flagged in this report. The following application was recommended for reinstatement to the medical staff office effective 9/01/2018 through 8/31/2020, 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:

- **CHU, James, MD/Pediatric Cardiology**

RESIGNATIONS: (Effective date 8/31/2018 unless otherwise noted)

Automatic:

- **SNYDER, Ole, MD/Family Medicine**
- **THUEN, Eric,/Surgery/Podiatry**

Voluntary:

- **LENNARD, William, MD/Anesthesiology**

Attachment B

- **MINGRONE, Christopher, MD/Anesthesiology**
- **NOEL, Sophonie, MD/Anesthesiology**
- **RODRIGUEZ, Madeline, MD/Obstetrics & Gynecology**
- **SCHOELLERMAN, Manal, MD/Radiology**
- **SHIMOMAYE, Susan, MD/Dermatology/Allergy**
- **TAYLOR, Tasha, MD/Pediatrics**
- **ZORRILLA, Juan, MD/Emergency Medicine**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
August 8, 2018

Attachment C

PROCTORING RECOMMENDATIONS (Effective 8/31/18, unless otherwise specified)

- **BALL, Lindsey MD** — **Emergency Medicine**
- **DALLA BETTA, Michael DO** — **Emergency Medicine**
- **FERNANDEZ, Janice MD** — **Anesthesiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
August 8, 2018

Attachment B

NON-REAPPOINTMENT RELATED STATUS MODIFICATIONS
PRIVILEGE RELATED CHANGES

AUTOMATIC EXPIRATION OF PRIVILEGES
The following practitioners were given 6 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of 8/31/2018.

- **O'BRIEN, Mark DO** — **Internal Medicine**

Tri-City Medical Center

Delineation of Privileges

Pediatrics - 8/17

Provider Name:

Request	Privilege	Action MSO Use Only

CERTIFICATION: 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.

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

Level 1 and Level 2 Newborn Criteria:
Initial: Training and evidence of current NRP/NALS or PALS certification
Proctoring: Six (6) cases (Any combination of proctoring from Admit patients, Consultation, Newborn Care, or H&P)
Reappointment: Evidence of current NRP/NALS or PALS certification

___ Newborn care, Level 1 and Level 2

___ Admit patients, Level 1 and Level 2 newborns

___ Perform medical history and physical examination (newborn), including via telemedicine (F)

___ Consultation, including via telemedicine (F)

___ Refer and follow
Physicians with this privilege may refer patients to the hospital and follow their progress, but an attending physician would provide necessary care. This privilege will allow the physician to visit patients, read records, and refer patients to specialists. SELECTION OF THIS PRIVILEGE IS EXCLUSIVE. NO OTHER PRIVILEGES MAY BE REQUESTED IN CONJUNCTION WITH THE REFER AND FOLLOW PRIVILEGE. *REFER AND FOLLOW IS NOT A CLINICAL PRIVILEGE*

___ ~~**INVASIVE PEDIATRIC PROCEDURES** - By selecting this privilege, you are requesting the Invasive Pediatric privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.~~

~~Invasive Pediatric Procedures Criteria:~~
~~Initial: Training and as indicated for specific privileges below~~
~~Proctoring: Three (3) cases from Invasive Pediatric Procedures category~~
~~Reappointment: See privileges below~~

~~Circumcision~~
~~**Initial and Reappointment:** Case documentation showing five (5) procedures over the past 24 month period.~~

___ **PEDIATRIC CARDIOLOGY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Cardiology privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Pediatric Cardiology Procedures Criteria:
Initial: Successful completion of a residency in Pediatrics and a fellowship training program in Neonatology or Pediatric Cardiology
Proctoring: Two (2) cases from this category
Reappointment: Ten (10) cases from this category per two-year reappointment cycle

Cardiac defibrilation, to include neonates

Consultation, Pediatric Cardiology, to include neonates

Tri-City Medical Center
Delineation of Privileges
Pediatrics - 8/17

Provider Name:

Request	Privilege	Action MSO Use Only

Echocardiography, to include neonates

Elective cardioversion, to include neonates

Electrocardiography (EKG/ECG), to include neonates

Pericardiocentesis, to include neonates

___ **PEDIATRIC SURGERY PRIVILEGE CATEGORY** - By selecting this privilege, you are requesting the Pediatric Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want. ___

Pediatric Surgery Privilege Criteria:
Initial: Board certified by the American Board of Surgery in Pediatric Surgery
Proctoring: One (1) cases from this category
Reappointment: Evidence demonstrating activity performing pediatric surgery at another healthcare facility

Consultation, Pediatric Surgery, to include neonates

___ Moderate Sedation ___

Moderate Sedation Criteria:
Initial and Reappointment - Refer to Medical Staff policy 8710-517 and evidence of current NRP/NALS certification

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

Approval:

_____
Division/Department Signature

_____
Date

ADMINISTRATION CONSENT AGENDA
August 20th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Admission Criteria Policy	Practice Change	Forward To BOD For Approval
2. Census Zones, Managing of Policy	3 Year Review, Practice Change	Forward To BOD For Approval
3. Clinical Alarm Management Policy	3 Year Review, Practice Change	Forward To BOD For Approval
4. Code Caleb Response Plan Policy	Practice Change	Forward To BOD For Approval
5. Latex Sensitivity-Allergy Management Policy	3 Year Review, Practice Change	Forward To BOD For Approval
6. Patient Rights and Responsibilities 302 Policy	Practice Change	Forward To BOD For Approval
7. Staff Development-Education Policy	3 Year Review, Practice Change	Forward To BOD For Approval
8. Staffing, Registry-Traveler Usage Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Administrative		
1. Legal Documents 294 Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Behavioral Health Services		
1. Emergency Medication Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Education Department		
1. Learning Needs Assessment Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Infection Control		
1. Bloodborne Pathogen Exposure Control Plan Policy	1 Year Review, Practice Change	Forward To BOD For Approval
2. Healthcare Associated Infections, Defined IC 4 Policy	DELETE	Forward To BOD For Approval
3. IC 5.2 Pregnant Healthcare Workers (Informational Handout)	DELETE	Forward To BOD For Approval
Lab Gen Lab QA Manual		
1. Individualized Quality Control Plan Policy	2 Year Review, Practice Change	Forward To BOD For Approval
Mammography Women's Center		
1. Consumer Complaint Mechanism DIT Policy	DELETE	Forward To BOD For Approval
2. Enhancing Quality using the Inspection Program (EQUIP) Policy	NEW	Forward To BOD For Approval
3. Health Physicist Testing Policy	DELETE	Forward To BOD For Approval
4. Implants Policy	3 Year Review, Practice Change	Forward To BOD For Approval
5. Infection Control Policy	DELETE	Forward To BOD For Approval
6. Master Jacket Retrieval & Filing Policy	DELETE	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
August 20th, 2018

CONTACT: Sharon Schultz, CNE

Policies and Procedures	Reason	Recommendations
7. Personnel Orientation for OPIC Center DIT Policy	DELETE	Forward To BOD For Approval
8. Q.C. Policy Phantom Policy	DELETE	Forward To BOD For Approval
9. Q.C. Policy-All Policy	3 Year Review, Practice Change	Forward To BOD For Approval
10. Report Inclusions Policy	3 Year Review, Practice Change	Forward To BOD For Approval
11. Retake Repeat Analysis Policy	3 Year Review, Practice Change	Forward To BOD For Approval
12. Standardized Labeling of Mammograms Policy	3 Year Review, Practice Change	Forward To BOD For Approval
13. Training Orientation Competency and Continuing Education DIT Policy	DELETE	Forward To BOD For Approval
Medical Staff		
1. Credentialing Policy, Laser and Aesthetic Center 8710-565	DELETE	Forward To BOD For Approval
2. Cultural and Linguistic Proficiency 8710 - 601	3 Year Review, Practice Change	Forward To BOD For Approval
3. Joint Providership/Co-Providership 8710 - 602	3 Year Review, Practice Change	Forward To BOD For Approval
4. Medical Record Documentation Requirements 8710-518	Practice Change	Forward To BOD For Approval
5. Regularly Scheduled Series (RSS) 8710 - 606	3 Year Review, Practice Change	Forward To BOD For Approval
6. TB Screening of LIPs and Allied Health R-8710-538	3 Year Review, Practice Change	Forward To BOD For Approval
NICU		
1. Cleaning And Sanitizing of Specialty Bottles/Nipples	NEW	Forward To BOD For Approval
Security		
1. Morgue Release	DELETE	Forward To BOD For Approval
Ultrasound Vascular Imaging		
1. Cidex Protocol for Disinfection Process Policy	DELETE	Forward To BOD For Approval
Women & Newborn Services		
1. Nipple Shield and Supplemental Nursing System	DELETE	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**03/02**	**SUBJECT:**	**Admission Criteria**
REVISION DATE:	**10/02; 06/03, 05/05, 12/05, 05/09, 02/12, 08/12, 01/15**	**~~POLICY NUMBER: VI.A~~**	

Department Approval:	**~~06/16~~07/18**
Clinical Policies & Procedures Committee Approval:	**~~02/17~~07/18**
Nurse Executive Council Approval:	**~~02/17~~07/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/17~~07/18**
Professional Affairs Committee Approval:	**~~04/17~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**04/17**

A. **PURPOSE:**

1. To provide guidelines for the medical staff, nursing personnel, ancillary disciplines, and admitting personnel to ensure:
   a. A consistent process for admission of patients
   b. An appropriate level of care is based on patient's needs/situation

B. **POLICY:**

1. Admission Requirements:
   a. Hospital admission requires a physician's order.
   b. Patients may be admitted to inpatient or observation status per current InterQual guidelines.
      i. Patients must be 14 years of age or older to be admitted.
         1) Patient must be 18 years and above to be admitted to the Progressive Care Unit (PCU) or Behavioral Health Services (BHS) ~~including the Crisis Stabilization Unit (CSU)~~ and Inpatient Behavioral Health Unit (IBHU).
         2) Refer to Women and Newborn Services Neonatal Intensive Care Unit (NICU) Policy: Admission and Discharge Criteria for the NICU regarding infants up to adjusted 44 week post conceptual age
   c. The attending physician shall be designated by the admitting physician at the time of patient admission.
   d. The Administrative Supervisor (AS) /Assistant Nurse Manager (ANM) or designee assigns a bed based upon patient diagnosis, acuity, age, bed availability and physician/ request.
   e. Additional considerations:
      i. The decision to admit a patient continues to be the responsibility of the treating physician.
         1) If cases arise where the circumstances would pose a hazard to the patient's health and/or safety and the appropriate setting is in question, then the case shall be referred for secondary review per chain of command.
      ii. Each unit may have limitations of ability to care for certain types of patients in terms of physical layout, environment, equipment, staff expertise, availability, or patient acuity.

iii. Temporary staffing adjustments shall be made for those patients whose acuity level exceeds established guidelines.
1) If patient admission requirements exceed hospital bed and/or staffing capacity, AS collaborates with ANM, Charge Nurses and/or Managers, then forwards the request to hold admissions to the Clinical Operations On Call if deemed necessary.

iv. **Bed placement for those with specific gender identity or sexual orientation needs will be assigned on a case by case basis. This is to ensure that the patient's comfort and quality of care needs are met during their admission.**

f. Admission of patients to the nursing units may occur by any of the following methods:

i. Direct Admissions:
1) Patients may come directly from a physician's office, their home, a long-term care facility or outpatient department as ordered by a physician.
2) The physician calls the AS for a bed assignment per Patient Care Services (PCS) Policy Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC).
3) The AS shall conduct a telephone triage on the patient to assess status. Admission orders are required for each patient. The Registered Nurse will call the admitting physician for orders once the patient arrives to the nursing unit. Orders may also be faxed to Registration Department at 760-940-4016, entered electronically or sent with the patient.
4) The AS assigns the patient to the appropriate unit and informs the ANM/relief charge.
5) Ambulatory patients report to the Registration Department between the hours of 0500-1800 and to the Emergency Department between the hours of 1800-0500.
6) The Registrar notifies the unit that the patient has arrived. Patients admitted via Registration may be escorted to the nursing unit by the office staff or volunteer personnel.
7) Patients unable to complete the registration process in one of the registration areas due to severity of illness or discomfort shall be escorted directly to the nursing unit. These patients shall be registered at the bedside by a registrar or by a family member/conservator/designee in the registration office.
8) Patients experiencing acute symptoms shall be triaged in the Emergency Department (ED) prior to being escorted by clinical staff to the respective nursing units.
9) If an inpatient bed is unavailable, the patient may be:
a) Admitted to the ED for evaluation and treatment.
b) Requested to remain in physician's office until bed available.
c) Requested to remain home until bed available.

ii. Admissions to Acute Rehabilitation:
1) When a physician orders an inpatient be evaluated for admission to Acute Rehab, the Rehab Coordinator will determine if the patient meets the admission criteria.
2) Once approval is obtained, the patient must be discharged from the inpatient unit and admitted as a direct admit to Rehab with a new financial account number (FIN#) when a bed is available.
a) The inpatient unit secretary will request a Rehab bed in Aionex
b) The RN will complete the Depart process including all required documentation.
c) A Cerner communication notice will be sent to Registration upon transfer.

i) Registration will create the new **financial identification number** (FIN#).

iii. Emergency Admission:
1) ED admission to an inpatient unit:
a) After a physician determines that an Emergency Department patient will be admitted, the ED unit secretary will enter the bed request into Aionex, AS/ANM or designee will assign the bed in Aionex, and inputs the bed number into FirstNet.
2) ED patients being admitted to the BHS are converted to an Inpatient status with the same FIN # when a bed is available.
~~3) ED patients being admitted to the CSU are to be discharged from the ED and readmitted to CSU with a new FIN# when a bed is available.~~
~~a) If the patient is admitted to IBHU or must return to the ED, the patient is to be discharged from the CSU and a new account with new FIN# must be created.~~

iv. Transfer Admission:
1) The AS shall arrange patient transfers from another in-house patient care unit or outside facility.

v. Surgical Admission:
1) Surgery patients are pre-scheduled through Surgery Scheduling.
2) Surgery Scheduling schedules the appointment for **Pre-Operative Education**~~pre-admission procedures and teaching~~.
3) Surgery Scheduling generates a computerized list of pre-scheduled surgical admissions and forwards the list to the AS.
4) The AS assigns the bed and notifies the nursing unit.

vi. Outpatient Admissions:
1) Registration processes all outpatient admissions.

vii. Boarders:
1) WNS - Boarders are newborn infants admitted after delivery and not discharged with their mother. Boarders may be admitted to the newborn nursery or NICU based on infant status.
2) ED – Boarders are patients with admission orders greater than four (4) hours after a bed has been requested for inpatient admission or observation.

viii. The following departments coordinate admissions to their unit(s), see department specific admission criteria:
1) BHS – Inpatient ~~or (CSU)~~ – Outpatient Observation.
2) Neonatal Intensive Care Unit (NICU),
3) Acute Rehabilitation Unit (ARU or Rehab)
4) Women and Newborn Services
5) Progressive Care Unit (PCU)

2. Unit Specific Criteria:
a. Intensive Care Unit (ICU) (1 East, 1 West):
i. This level is appropriate to use when the patient has an acute cardiac, medical, surgical, or trauma event, along with any of the following:
1) Invasive hemodynamic monitoring
2) Urgent temporary pacemaker insertion
3) Urgent cardioversion
4) Intra-aortic Balloon pump (IABP)
5) Continuous cardiac monitoring
6) Acute intubation and mechanical ventilation management
7) Sepsis
8) Therapeutic Hypothermia
~~9) Dialysis~~

~~10)~~**9) Cardiovascular**~~Coronary Bypass~~ Surgery
~~11)~~**10)** Advanced Hemodynamic monitoring

ii. The following patients shall not be managed on this unit due to the lack of available resources:
1) Undergoing organ transplants
2) Requiring specialized burn treatments
3) Under the age of 14 or less than 35kg

b. Telemetry (2 East, 2 West, 4 East, 4 West, 3 Pavilion):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available cardiac monitored beds.
1) Continuous cardiac monitoring
2) Continued mechanical ventilation with stable ABG's and extended ventilator weaning
3) Stable temporary pacemaker insertion or transcutaneous pacing
4) See Telemetry Policy: Admission and Discharge Criteria

c. Progressive Care Unit (3 North, 3 South)
i. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
1) Continuous Cardiac Monitoring
2) Chemotherapy Administration
3) Acute rehabilitation
4) Ante-partum care
5) Post-partum care
6) Medical-Surgical

d. Acute Care Services (1 North, 2 Pavilion, ~~,~~4 Pavilion and Acute Rehabilitation):
i. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available beds.
1) Post critical care or Telemetry monitoring
2) Procedures requiring inpatient hospitalization
3) IV medications requiring hospitalization for initial therapy
4) Designated inpatient post surgical care.

ii. 1 North/Ortho (Ortho and Medical/Surgical Patients)
1) This unit specializes in nursing care for patient's ages 14 years of age and older suffering from diseases, injuries or conditions of the human musculoskeletal system.
2) Orthopedic diagnoses are emphasized **including**~~with an emphasis on~~ orthopedic surgeries **such as**~~including~~ total joint replacement~~,~~ **and** spinal surgeries~~ and hip replacements~~.

iii. 2 Pavilion (Oncology and Medical/Surgical Patients)
1) This unit provides nursing care for adolescent patients (ages 14 years to 21 years) or adult patients (age 22 years and older).
a) Patients receiving chemotherapy must be age 18 or older.
2) Oncological diagnoses are emphasized along with women's surgeries and general medical surgical diagnosis.

iv. 4 Pavilion (Dialysis, Rate Monitoring for Medical/Surgical patients, Designated Stroke Unit, and Epilepsy Monitoring Unit [EMU])
1) This unit specializes in nursing care for patients ages 14 years of age and older:
a) Medical/Surgical patients requiring rate monitoring
b) Hemodynamically stable patients status post CVA

c) Visual monitoring of stable epilepsy patients (EMU)

v. Acute Rehabilitation Unit (ARU)

1) The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services.

e. Emergency Services:

i. This unit provides nursing care for patients of all ages that:

1) Require medical care and are in stable, mild, moderate, or acute status.

2) Are afflicted with conditions involving major trauma, major burns, or requiring hyperbaric therapy, and pediatric intensive care services that can be stabilized to the degree medically feasible and subsequently transferred to facilities providing these specialty services in compliance with **Emergency Medical Treatment and Active Labor Act** (EMTALA) regulations.

f. Women and Newborn Services:

i. This unit specializes in nursing care for:

1) Perinatal patients who have conditions associated with antepartum, intrapartum and/or postpartum management needs to include surgical requirements related to perinatal care.

2) Neonates ~~born in the hospital~~ that may need resuscitation, stabilization and ongoing evaluation.

C. RELATED DOCUMENTS:

1. Behavioral Health Unit Inpatient Policy: Inpatient Unit Admission Criteria
2. Patient Care Services Policy: Transferring of Patients and Recovering Patients from Outside TCMC
3. ~~PCS~~ **Patient Care Services** Policy: Transfer of Patients, Intra Facility
4. Surgery Policy: Scheduling Surgical Procedures
5. Telemetry Policy: Admission and Discharge Criteria
6. Women Newborn and Services NICU Policy: Admission and Discharge Criteria for NICU

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 4/06	**SUBJECT: Census Zones, Managing of**
REVISION DATE: 6/06, 8/08, 4/11	**~~POLICY NUMBER: I.G~~**
Department Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	**~~11/14~~06/18**
Nursing Executive Committee Approval:	**~~11/14~~07/18**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~01/15~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**01/15**

A. **PURPOSE:**

1. To provide a management plan for Tri-City Medical Center that shall ensure appropriate and consistent inpatient access which ensures patients have access to appropriate and consistent care during periods of high census.

B. **POLICY:**

1. The management of patient volume is essential in order to minimize delay and/or diversion of patients into Tri-City Medical Center.
2. In order to initiate the appropriate census management activities, the census zone status shall be communicated to nursing each day at the daily bed meetings.
   a. Daily bed meetings occur 7 days a week at ~~1530, and 0315~~**a designated time each shift.**
3. The Administrative Supervisor (AS) shall document census zone status on the Staffing, ~~and~~ Patient Flow worksheet **and daily census.**
4. Daily bed census information is communicated to shift supervisors or designees supporting patient care in the daily census report that is sent out via email.
5. All bed requests will be entered into Aionex to facilitate tracking and patient placement.
6. The number of available beds/staff determines the census management zone level.

C. **DEFINITIONS:**

1. Available Bed:
   a. Staffed
   b. Empty and clean
   c. Empty and dirty
   d. Occupied – pending discharges
   e. Occupied – pending transfers
2. Green Census Zone:
   a. Availability of beds is adequate
   b. Staffing is adequate
   c. Emergency Department (ED) has available beds
   d. Many discharges/transfers anticipated
   e. Inpatient beds available to accommodate surgery schedule
3. Yellow Census Zone:
   a. Availability of beds is limited
   b. Staffing limited, premium, and/or incentive pay has been offered to staff and agencies

c. ED is full, no admissions holding
d. Limited discharges/transfers anticipated
e. Inpatient beds are limited to accommodate surgery schedule

4. Red Census Zone:
   a. No availability of beds
   b. Premium and/or incentive pay has been offered to staff and agencies with insufficient response
   c. House-wide resources are limited
   d. ED is full and/or on diversion and patients are being held for admission
   e. Census is at capacity in all inpatient care areas (excluding OB Couplets)
   f. Inpatient beds not available to accommodate surgery schedule
   g. Postanesthesia Care Unit (PACU), Emergency Department (ED), Cath Lab, and ~~Special Procedures Recovery Area (SPRA)~~ **Outpatient PACU** may have patients delayed for inpatient bed placement

5. Leadership Team:
   a. The leadership team consists of the Chief Nurse Executive (CNE), AS, Assistant Nurse Manager (ANM), Case Manager/Discharge Planner, all Managers, Directors, Medical Staff Office, Environmental Services (EVS) Delegate, and Educators.

D. **PROCEDURE:**

1. During the "Green Census Zone":
   a. The ANM/designee for each inpatient care unit shall ensure appropriate assignments of patients to staff.
   b. Potential discharges shall be identified.
   c. Patient Flow shall be evaluated by the leadership team.

2. During the "Yellow Census Zone":
   a. The leadership team shall assess staffing; confirm resources for overflow capacity, beds, surgery schedule, and ED census to prepare for possible "Red Census Zone."
   ~~b. Offer premium and/or incentive pay to staff and agencies.~~
   ~~c.~~**b.** **Clinical** Directors/~~managers~~ **Managers** shall assist ANMs and staff with patient placement and acuity by contacting physicians to downgrade or discharge patients as appropriate.
   ~~d.~~**c.** **Hospitalists** ~~Director of Medical Staff~~ shall be contacted to assist with physician communication **regarding discharges**.
   ~~e.~~**d.** **Vacant** ~~P~~patient ~~Overflow~~ areas shall be prepared for use. This includes contacting Patient Accounting to advise that patients may be admitted to the following overflow areas:
      ~~i. 2 South – OB/GYN or Med/Surg patients~~
      ~~ii.~~**i.** PACU/~~SPRA~~**Outpatient PACU** – Primarily ICU, Telemetry
      ~~iii. Nursery – NICU Overflow~~
      ii. 1 North/Rehab – Med/Surg, need California Department of Public Health (CDPH) approval for Rehab.
      iii. 3 Pavilion and 3 East
      iv. **Station D**
   ~~f.~~**e.** Same nursing department standards shall be followed in the **areas accepting** overflow **patients**~~areas~~.

3. During the "Red Census Zone":
   a. If immediate crisis occurs, ensure Yellow Zone procedure is initiated.
   b. The AS shall:
      i. Initiate overflow plan(s) and mobilize staffing resources.
      ii. Prioritize patient bed assignment and admissions as beds become available.
      iii. Notify Nursing Leadership.
      iv. Notify the Clinical Operation Leader.
      ~~iv.~~**v.** **Notify Hospitalists**
   c. The EVS Supervisor shall page for a STAT bed clean for all available beds.

d. The ~~Directors~~ **Leadership** of Surgical Services, Radiology, Nurses, and Medical Staff office shall evaluate elective procedures on Radiology and surgical schedules for potential delays/reschedules and communication strategies to physicians.
e. Case Managers/Discharge Planners shall:
   i. Assess for potential discharges.
   ii. Contact Medical Directors to triage patients out of areas.
f. The ~~Director~~ **Leadership** of Supply Chain Management **and Sterile Processing** shall evaluate the need to rent extra monitors and/or equipment and provide extra supplies to units.
g. Biomedical Engineering and Sterile Processing Departments shall provide additional supplies and equipment as needed from internal and external sources to include contracted vendors.
h. The Director of Food & Nutrition shall evaluate the need for additional food requests.
i. The Director of Pharmacy shall evaluate the need for increased pharmacy services.

4. The ANM/designee shall make rounds on the units to assess the Census Status and communicate pending discharges to the AS.
5. During the "Red Census Zone," status updates shall be given every 4 hours to Nursing Leadership.
6. Nurse Managers/designee and the AS shall meet to assess overall staffing and census zone status.
7. Medical recommendations for "Red Census Zone" are as follows:
   a. Admitting patients is dependent upon discharges. Physicians shall be asked to re-evaluate for discharges and transfers to accommodate admissions.
   b. Patients leaving within one (1) hour and awaiting rides shall be moved to **a staff area that is vacant**~~waiting lounges with staff oversight~~.
   c. Case Managers/Discharge Planners/**Social Workers** shall facilitate skilled nursing facility discharges as a top priority.
   d. Elective cases **may need** to be cancelled **in accordance with C Suite approval**~~shall be discussed with the Director of Perioperative Services~~.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~NEW~~ **12/15** **SUBJECT: Clinical Alarm Management**

REVISION DATE(S):

Department Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	~~09/15~~**06/18**
Nurse Executive Committee Approval:	~~09/15~~**07/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~10/15~~**07/18**
Professional Affairs Committee Approval:	~~11/15~~**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**12/15**

A. **DEFINITION(S):**
1. Clinical alarms: Alarms on equipment or devices used for physical or physiological monitoring to protect the patient.
2. Alarm fatigue: Desensitization of clinicians due to exposure to excessive alarms.
3. Nuisance Alarms – non actionable alarms which do not require medical intervention.

B. **POLICY:**
1. This policy ensures the effectiveness of clinical alarm systems by providing regular preventative maintenance and testing of alarm systems; assuring that alarms are activated with appropriate settings and are sufficiently audible with respect to the distances and competing noise within the unit; and defines the roles and responsibilities for alarm management.
2. Patients requiring medical equipment with clinical alarms will be placed in the appropriate patient care settings. ~~:~~(Refer to ~~the~~ **Patient Care Services Policy:** Admission Criteria ~~policy in the Patient Care Services Policy Manual.~~).
3. Alarm signals and parameter management: Failure to hear or respond to critical alarms may lead to unintended patient harm.
   a. Alarms on clinical monitoring and intervention systems will be maintained in the "on" position and sufficiently audible to staff.
      i. Alarms will be turned on by the clinician initiating the clinical monitoring.
      ii. Alarms may not be turned off. Alarms will be "on" as long as the equipment is being used for the patient.
         1) Alarms may be suspended during direct patient care.
         2) All alarms must be resumed prior to the caregiver leaving the room.
         3) Alarms will not be set to such extremes that they fail to detect significant changes in a patient's condition.
   b. Alarm parameters:
      i. Alarm parameters should be initially set at the manufacturers default settings or to area/unit specific criteria.
      ii. Parameters may be adjusted by a licensed clinician (within their scope of practice) based on the patient's clinical condition to reduce nuisance alarms and alarm fatigue.
         1) The licensed clinician may set alarms within closer parameters, but never any less than the documented standard.

iii. Staff at the beginning of each shift or when care is initiated will ensure alarms are on and review the patient's alarm parameters, including alarm volume.
iv. Patient and/or family education regarding clinical alarms and parameters will be done by the RN/clinician as needed throughout the shift to decrease alarm induced anxiety and increase patient involvement in their care.

4. Responsible personnel
   a. The Clinical Alarm Management Team and Medical Executive Committee (MEC) are responsible for establishing alarm management guidelines based on manufacturer's recommendations and published best practices.
   b. Directors and managers, or designee, are responsible for assessing staff competency and for providing training in the operation of medical and monitoring equipment to include the use of alarm systems.
   c. Registered nurses (RN) are responsible for ~~the~~ setting and validating ~~of~~ clinical alarms.
   d. A Monitor Technician (MT) will notify an RN or Advanced Care Technician (ACT) immediately when a patient's cardiac rhythm is not visible on the central monitor station.
      i. The MT shall not change default cardiac settings or make parameter adjustments unless directed by the RN.
   e. Respiratory therapists are responsible for setting and validating ventilator equipment, alarm limits, function, and audibility.
   f. Licensed ancillary staff members (i.e. radiology technologists, MRI/CT specialists, Nuclear Medicine technologists) may within their scope of practice be responsible for setting and validating alarm limits, function, and audibility.
   g. Clinical engineering (biomedical) is responsible for preventative maintenance.
   h. All clinical staff shall respond promptly to any alarm intended to protect the patient receiving care.
   i. Other personnel are responsible for alerting the appropriate clinician of a clinical alarm, but not adjusting unless within the scope of their training.
   j. All staff are responsible to identify the source of an alarm and notify the appropriate clinical staff for evaluation and intervention.
5. Alarm audibility:
   a. The volume level of clinical alarms must be sufficiently audible with respect to distances and competing noise to be heard by the responsible clinicians in the immediate patient care area. The layout of the unit may impact the ability to hear certain alarms and require one or more of the following actions:
      i. Alarm volume to be adjusted upward at certain times of the day based upon the noise level and activity in the patient care area.
      ii. The patient's room/physical location may ~~n~~ be moved to ensure audibility of the alarms.
      iii. An area for charting may be set up closer to the patient's room to ensure audibility of alarms (zone charting).
      iv. Door to patient's room kept open, or partially open with the exception of select patient situations (i.e. isolation precautions, ~~custody patients,~~ fire alarms, or specific patient/family requests).
      v. In the event that the door to the patient room is closed, alarm audibility will be validated by the RN outside the closed door.
   b. Critically ill patients must have cardiac monitors and/or ventilators visible from outside the patient room.
      i. If the door to the patient's room is required to be closed, the curtain in the room will be kept partially open to allow for adequate visibility of the patient and the monitoring device.
6. Maintenance and testing of alarm systems
   a. Engineering is responsible for the preventative maintenance of all medical equipment and alarm devices. ~~(~~Refer to ~~the~~ **Engineering Policy:** Equipment Management Plan~~)~~
   b. Clinical Engineering will maintain a current inventory of all medical equipment.

c. Alarm malfunctions and apparent malfunctions must be reported to Biomedical Engineering via the online work order system found on the TCMC Intranet.
   i. Equipment with malfunctioning or apparent malfunctioning alarms must be taken out of service and evaluated by Biomedical Engineering personnel. . Refer to policy 8610-396: Incident report –Quality Review Report (QRR).

C. **RELATED DOCUMENT(S):**
1. NICU Procedure: Pulse Oximetry
2. NICU **Policy**: Standards of Care
3. Patient Care Services Policy: Admission Criteria
4. Patient Care Services Policy: Pulse Oximetry
5. Patient Care Services **Standardized Procedure**: Standards of Care, Adult
6. Pulmonary Procedure: Mechanical Ventilation (Initial Set Up Protocol, Management and Troubleshooting)
7. Telemetry Unit Specific Policy: Management of Telemetry Patient 6150-108
8. Telemetry Unit Specific Procedure: Monitoring Telemetry Patients Using the DASH 3000
9. Women~~'s~~ & Newborn Services **Standardized Procedure**: Standards of Care, **Intrapartum**
10. Women~~'s~~ & Newborn Services **Policy**: Standards of Care, Newborn
11. Women~~'s~~ & Newborn Services **Policy**: Standards of Care, Postpartum

D. **REFERENCES ~~LIST~~:**
1. The Joint Commission Perspectives, July 2013, Vol.33, Issue 7.
2. ECRI Institute: Strategies to Improve Alarm Safety, 2014

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11

SUBJECT: Code Caleb Response Plan

REVISION DATE: 02/12, 01/18

~~**POLICY NUMBER: IV.ZZ**~~

Department ~~Review~~Approval:	**01/18**
Clinical Policies & Procedures Committee Approval:	**~~01/15~~02/18**
Nurse Executive Council Approval:	**~~02/15~~03/18**
Division of Neonatology Approval:	**~~01/15~~05/18**
Department of Emergency Medicine Approval:	**~~01/16~~06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~07/18**
Professional Affairs Committee Approval:	**~~03/16~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary event and/or other emergent clinical conditions for infants up to 30 days **of age or 44 weeks corrected gestational age,** ~~old~~-within the hospital and outside of the facility on hospital property.

B. **DEFINITION(S):**

1. Infant: newly delivered, which includes prematurely, and up to 30 days ~~old~~**of age or 44 weeks corrected gestational age.**
2. Code Caleb Response Areas:
   a. Patient Care Areas- areas in the main building where neonatal crash carts are readily available (for example Emergency Department ~~([~~[ED]~~)~~, Women and Newborns Services, Neonatal Intensive Care Unit ~~([~~[NICU~~)]~~]).
   b. Non-Patient Care Areas- areas on the main campus where neonatal crash carts are not readily available (for example the lobby, registration area, and parking area).

C. **POLICY:**

1. A Code Caleb shall be called for any infant in need of stabilization or resuscitation.
2. Any person may initiate a Code Caleb by dialing "66" on the telephone. The operator shall announce "Code Caleb" and the location over the Public Announcement (P.A.) system three times, twice.
3. The Neonatal Resuscitation Program (NRP) guidelines shall be used to direct the resuscitation efforts for those infants on the Labor and Delivery (L&D), Mother Baby Unit and ~~Neonatal Intensive Care Unit (~~NICU~~)~~.
4. The Pediatric Advanced Life Support (PALS) and/or NRP guidelines may be used to direct the resuscitation efforts for those infants requiring assistance in the ED and Non-Patient Care Areas based on the responder's training.
5. It is expected that the first responders begin infant **cardiopulmonary resuscitation** (CPR) until the Code Caleb Response Team arrives.
6. The following personnel make up the Code Caleb Response Team:
   a. NICU Nurse:
      i. Supports resuscitation interventions and initiates **NRP per Patient Care Services** Standardized Procedure:~~ for~~ Code~~.~~ Caleb until the Neonatologist arrives.

ii. **Brings the "Infant Resuscitation Bag" when responding to a Non-Patient Care Areas.**
~~ii.~~**iii.** Starts intravenous (IV) line, assists with central line placement as indicated.
~~iii.~~**iv.** Ensures temperature loss is minimized especially if the infant is premature.
~~iv.~~**v.** Prepares medications for administration and may delegate the task.
~~v. Brings the "Infant Resuscitation Bag" when responding to a Non-Patient Care Areas.~~

b. **Respiratory Care Practitioner** (RCP):
i. Provides airway management.
ii. **Brings ~~oral airway and pediatric~~neonatal/infant airway bag if responding to Non-Patient Care Areas.**
~~ii.~~**iii.** Assists with intubation.
~~iii.~~**iv.** Obtains arterial blood gases (ABG's) as indicated.
~~iv. Brings oral airway and pediatric airway bag if responding to Non-Patient Care Areas.~~

c. Neonatologist:
i. Responds, when available, and is responsible for leading the resuscitative efforts.
ii. Responsible for intubation and central line placement as indicated.
iii. Determines where the infant will be transported for stabilization.

7. Other support roles and responsibilities during the Code Caleb include:
a. Security Personnel:
i. Maintains scene safety and keeps area clear of congestion.
b. Assistant Nurse Manager **(ANM)**/-Relief Charge Nurse:
i. Assigns recorder role, if not already done.
ii. Ensures paperwork and documentation on the Neonatal Resuscitation Record and the Emergency Event form in the patient's electronic health record (EHR) are completed.
iii. Ensures the medication tray inside the neonatal crash cart is relocked with a secure tie (located in the crash cart) for containment post code.
iv. Ensures the "opened" crash cart is locked with the plastic key lock externally, is placed in a secured area. and the Sterile Processing Department (SPD) is notified to pick up the used cart post code.
c. Ancillary Support (-Social Worker-, Chaplain):
i. Provides support to the family by providing comfort, presence and updates as available.
d. SPD:
i. Brings another Neonatal Crash Cart and **one** (1) infusion pump with **one** (1) channel and **one** (1) syringe pump attached to the scene.

8. The response to the Code shall occur according to the following response plans.

D. RESPONSE PLAN IN L&D AND MOTHER BABY UNIT:

1. First responder at emergent event:
a. Calls for assistance **or delegates someone to dialing 66 for Code Caleb.**
b. Moves the infant to the radiant warmer for resuscitation.
i. On the Mother Baby Unit/ 2 **South** overflow, infant CPR shall begin as the infant is transported in an open crib to the radiant warmer in the transition nursery or infant treatment area.
c. Begins ventilating the infant using positive pressure ventilation (PPV) per NRP guidelines until Code team arrives.

2. Unit Secretary-/-Available Staff member:
a. Initiates a Code Caleb:
~~i. Uses the white phone line to call the NICU directly.~~
~~1) Pages the Neonatologists~~

~~2) Pages the RCP~~

~~ii.~~**i.** ~~May d~~Dial ~~"~~66~~"~~ to have Code **Caleb** announced over the P.A. system if needed.

3. Second Responder:
   a. Assists with resuscitation per NRP guidelines until Code team arrives.
   b. Attaches pulse oximetry lead.
   c. Assists with chest compressions.
4. Obstetrical Technician, Acute Care Technician/-Perioperative Aide:
   a. Brings the Neonatal crash cart to the scene.
   b. Brings the Neonatal Transporter to the scene.
   c. Acts as a runner for supplies, labs, etc.

E. RESPONSE PLAN IN THE NICU:

1. First Responder:
   a. Calls for assistance.
   b. Begins CPR and moved infant to radiant warmer for resuscitation.
   c. Begins ventilating infant per NRP guidelines.
2. Unit Secretary/-Available Staff member:
   a. Calls/pages the Neonatologists.
   b. Calls/pages the RCP.
3. Second/Third Responders:
   a. Brings Neonatal crash cart to the bedside.
   b. Assists with resuscitation per NRP guidelines.
4. **Registered Nurse (RN):**
   ~~c.~~**a.** Assists with line placement **and medication preparation** as needed~~, medication preparation~~.

F. RESPONSE PLAN IN THE ED:

1. First Responder:
   a. Calls for assistance.
   b. Begins CPR per PALS guidelines until Code Team arrives.
2. Unit Secretary/-Available Staff member:
   a. Dials ~~"~~66~~"~~ and requests Code Caleb be announced.
3. Second Responder:
   a. Assists with resuscitation per PALS guidelines until Code Team arrives.
4. Emergency Medical Technician (EMT):
   a. Brings the infant radiant warmer to the scene, plugs it in and turns the warming power to 100%.
   b. Brings the Neonatal crash cart to the scene.
5. ED Nurse:
   a. Responsible for the initial resuscitation efforts.
   b. Collaborates with the NICU nurse and Code Caleb response team upon arrival.
   c. May attempt IV access, as indicated.
   d. Ensures infant temperature loss is minimized especially if premature.
6. ED Provider:
   a. Directs initial resuscitation efforts.
   b. Works collaboratively with Neonatologist upon arrival.
   c. May intubate and place an Interosseous (IO) device.

G. RESPONSE PLAN IN NON-PATIENT CARE AREAS:

1. First Responder:
   a. Calls for assistance
   b. Begins CPR until the Code Caleb Response Team arrives.
2. The NICU Nurse, RCP and Neonatologist:
   a. -Ensure PALS or NRP guidelines have been implemented.

b. -Arrange for transport to the ED or NICU as soon as possible.

H. RESPONSE PLAN AT AFFILIATED CENTERS:

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center
   k. Tri-City Wellness Center
2. ~~The c~~Staff members are to initiate CPR and call 911 to facilitate management and transport of the infant to the ED.
3. The staff in home care, partial hospitalization, and outpatient rehabilitation services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities~~zes~~ respond.

~~I. FORM:~~

~~1. Neonatal Resuscitation Record~~

~~J.~~I. RELATED DOCUMENT(S):

1. Patient Care Services Standardized Procedure: Code Caleb
2. ~~PCS Code Pink Response Plan Policy~~
3. ~~PCS Code Pink Standardized Procedure~~

~~K.~~J. REFERENCE(S):

1. Neonatal Resuscitation Program (NRP), 7~~6~~th Edition (201~~6~~4). American Academy of Pediatrics and American Heart Association.
2. Pediatric Advanced Life Support (PALS). 201~~6~~4. American Heart Association and American Academy of Pediatrics

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/02	**SUBJECT:** Latex Sensitivity/Allergy Management
REVISION DATE: 12/02, 4/05, 6/08, 07/11	~~**POLICY NUMBER: IV.X**~~

Department Approval:	**03/18**
Clinical Policies & Procedures Committee Approval:	**~~12/14~~04/18**
Nursing Executive Council Approval:	**~~12/14~~04/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~01/15~~05/18**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~02/15~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**02/15**

A. **PURPOSE:**
1. Tri-City Medical Center seeks to create a latex-safe environment whenever possible and by doing so:
   a. Decrease risk of developing latex sensitivity/allergy
   b. Decrease symptoms due to latex sensitivity/allergy in sensitized-allergic employees and patients

B. **POLICY:**
1. The following are possible routes of exposure to latex allergens:
   a. Skin – via gloves, tapes, masks, tourniquets
   b. Mucous membranes – via products used in dentistry, anesthesia, rectal examinations, and eye droppers
   c. Inhalation – via aerosolization of glove powder
   d. Internal tissue – via latex products used in surgery
   e. Intravascular – via intravenous (IV) catheters, devices used to deliver IV fluids and injectables (syringes and IV administration sets) or rubber stoppers on medication vials.
2. Patient care staff shall be educated about latex safe environment and patient care issues.
3. At the time of admission, all patients are asked if they are allergic to latex by the nursing staff. The nursing staff shall provide patient education materials to patients known to have a latex sensitivity/allergy.
4. If a patient is known to have a latex sensitivity/allergy, latex precautions shall be used in their care.
   a. Place a latex allergy sign on the patient room door.
   b. Place latex allergy band on patient.
   c. Pharmacy and Food & Nutrition Services shall be notified of patient sensitivity/allergy to latex.
   d. The latex allergy shall be documented in the medical record, electronic medication administration record (eMAR) and entered into the pharmacy computer system.
   e. The need for latex precautions shall be communicated before a latex sensitive/allergic patient is sent to another department.
   f. To the extent possible, latex-free products shall be used in the care of the patient.
      i. The majority of single-use, disposable products used in our facility are latex-safe.
      ii. Supply Chain Management shall label all products known to contain latex with a sticker indicating product contains latex.

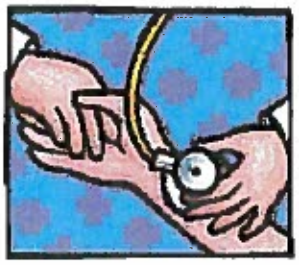
iii. ~~Supply Chain Management shall ensure latex-safe supply needs related to specific patient populations or patient care procedures are available if needed.~~

g. All health care workers who provide care to the patient or other patients within the room shall wear latex-free gloves.

5. All drugs to be used must be supplied in containers without a rubber stopper (i.e. glass ampules or screw top bottles). Where this is not possible, use a filter needle to draw up the medication and change the needle prior to administering the medication.
   a. If contact with a latex product cannot be avoided, consult the patient's physician to determine need to medicate patient for prophylaxis.
   b. Caregivers who observe allergic reactions such as skin rashes, hives, flushing, itching, nasal, eye or sinus symptoms, respiratory distress, and shock in patients following the use of latex-containing products shall report this reaction immediately to the patient's physician. Treat as clinically indicated for any allergic/anaphylactic reaction. Complete an incident report for all adverse drug reactions.
6. Placement in Airborne Precaution room shall be avoided for patients with latex allergens due to the negative pressure potentially drawing latex allergens into the room.
   a. If the patient requires Airborne Precautions, the negative pressure room shall be used without modification.
7. The Hospital prohibits latex balloons on all units. The Hospital does not sell latex balloons in the gift shop and requires florists and other gift suppliers who deliver to the Hospital to use mylar, rather than latex balloons.

C. **RELATED DOCUMENTS:**
1. Latex Allergy Patient Education
2. Latex Allergy Signs & Symptoms of an Allergic Reaction

LATEX ALLERGY



A latex allergy occurs any time a reaction is caused by bodily contact (via touching or breathing) with latex. Most problems can be prevented by protection from contact. Repeated contact with latex increases the chance of acquiring a latex allergy and may worsen the reaction.

Many items contain latex

There are many places, including medical settings, where one may come into contact with hundreds of products made with latex. Only products used as medical supplies are required by law to be labeled as "latex-free" or "containing latex." The following is only a partial list.

Common items made with latex:

Band-Aids	Elastic in clothing	Paints	Rubber bands
Balloons	Erasers	Baby bottle nipples	Condoms
Hot water bottles	Rubber toys	Pacifiers	Art supplies

More detailed lists and latex allergy information may be found at various website addresses, including the following:

www.sbaa.org
www.latexallergyresources.org
www.osha-slc.gov/SLTC/latexallergy/index.html
www.latex-allergy.org

Protect yourself from exposure to latex

Remember to report the need for latex precaution in each and every medical visit and in community places. These places include hospitals, clinics, doctor and dentist's offices, pharmacies, nursing homes, day care, schools, and work settings. You have the right to question the latex content of any product used in each setting.
Wear some form of medical identification if you are allergic to latex and follow instructions given to you by your nurse or doctor at all times. This may include taking medication.

Signs and symptoms of an allergic reaction

A response to latex may occur right away or not happen for hours after contact with an object. Sometimes it is hard to know which object caused it. The following may be symptoms of a latex allergy. It is very important to respond to these symptoms.

Seek medical help immediately if the person has difficulty breathing, complains of chest pains, or seems in general distress.

Skin: Rash, swelling, hives, itching, redness, and irritations. This reaction may be small or cover large areas of the body.

Eyes: Itching, tearing, watering, redness

Nose/throat: Runny nose, tightness and/or swelling of the throat, sneezing, itching

Lungs: Shortness of breath, difficulty breathing, wheezing

Heart: Chest pain, palpitations, lightheaded, fast heart beat, drop in blood pressure

Intestine: Abdominal cramping, diarrhea, nausea, vomiting

Food and Latex Allergy

There is a strong cross-reaction between some food allergies and latex allergy. Food sensitivity or allergy may exist before the onset of latex allergy. It may develop at the same time or after the latex allergy.

Cross-Reactive Foods

Certain foods are more likely than others to cause this reaction. These are called cross-reactive foods. Persons allergic or sensitive to latex may react to all, some, or none of the cross-reactive foods. Foods include bananas, avocados, kiwi and chestnuts. Other foods with a lower association include apples, carrots, celery, tomatoes, papaya, melons and potatoes.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

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

Department Approval:	**~~03/17~~07/18**
Clinical Policies & Procedures Committee Approval:	**~~03/17~~07/18**
Nurse Executive Committee Approval:	**~~05/17~~07/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/17~~07/18**
Professional Affairs Committee Approval:	**~~07/17~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

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

B. **DEFINITION(S):**

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

C. **POLICY:**

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

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

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

E. **REFERENCE(S):**

1. California Hospital Association Consent Manual 2017

Conditions of Admission – Sample

CONDITIONS OF ADMISSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

_____ _____ ___/___/___ ___:___ AM/PM
Name: Patient/Legal Representative Signature: Patient/Legal Representative Date (m/d/y) Time

If signed by other than patient, indicate relationship:

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

If patient is unable to sign, state reason: _____

☐ Interpretation provided: Language: _____

☐ Telephonic ☐ VRI _____
Interpreter: Name or ID No.

☐ Face-to-face interpreter Signature: _____

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

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

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

Signature: _____ _____
(Financially responsible party) *(print name)*

Date/Time: _____

Witness: _____ _____
(TCMC representative) *(print name)*

Date/Time: _____

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

CONDITIONS OF ADMISSION

8560-4011
(Rev. 8/15)

Affix Patient Label

Justice Involved Patient's Rights and Responsibilities – Sample

JUSTICE INVOLVED PATIENT'S RIGHTS & RESPONSIBILITIES

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

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

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

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

Received by _____ Date / Time _____

Witness _____ Date / Time _____

Affix Patient Label

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

7085-1016
(Rev 07/16)

JUSTICE INVOLVED PATIENT'S
RIGHTS & RESPONSIBILITIES

Patient Rights Poster - Sample

Patient Rights

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

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

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

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

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

Patient Responsibilities

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

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

Tri-City Medical Center

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 3/02	**SUBJECT: Staff Development/Education**
REVISION DATE: 2/03, 5/05, 7/06; 10/08; 05/11	**~~POLICY NUMBER: VIII.L~~**
Department Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	**~~09/14~~06/18**
Nursing Executive Council Approval:	**~~10/14~~07/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~11/14~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**12/14**

A. **POLICY:**

1. The general organization of the Professional Education Department consists of a ~~Director of Education, Clinical Informatics and Staffing,~~ an American Heart Association (AHA) Training Center Coordinator, ~~a Nurse Informaticist,~~ a Clinical Documentation ~~Specialist~~**Coordinator**, Education Specialists, and secretarial support. ~~The Clinical Educators report to the Director via a matrix reporting schedule.~~
2. The Professional Education Department collaborates with the nursing management team to identify needs and formulate goals for nursing education.
3. The Chief Nurse Executive is ultimately responsible for staff development. This is accomplished through collaboration with the Education staff and the nursing management team.
4. Human Resources provide New Employee Orientation to all new employees. The Education Staff provides Nursing and ~~Cerner~~ **documentation** Orientation for all new nursing employees immediately following the new employee hospital orientation. This program introduces the new nursing employees to Tri-City Medical Center's administrative and patient care services policies and procedures, nursing philosophy, nursing standards, essential technical aspects of nursing practice, and documentation requirements in ~~Cerner~~**the electronic health record**.
5. The Education Staff coordinates and facilitates in-service education consisting of activities which assist personnel to fulfill assigned responsibilities specific to the performance standards of a nursing unit. These activities are conducted internally within the facility and are directed at current patient care services and unit specific structure standard and process standards. The aim of in-service is to maintain competency (in relation to existing standards); create new competency (in relation to newly developed standards); respond to Quality Assurance (QA) findings (convert non-compliance to compliance).
6. The needs identified for training and education are based on, as appropriate:
   a. The patient population served and the type and nature of care provided by the hospital and the department/service
   b. Individual staff member needs
   c. Information from quality assessment and improvement activities
   d. Needs generated by advances made in health care management and health care science and technology
   e. Findings from department/service performance appraisals of individuals
   f. Findings from review activities by peers, if appropriate
   g. Findings from the organization's plant, technology, and safety
   h. Findings from infection control activities

7. Staff or management may make requests for special classes to the Professional Education Department who will evaluate the scheduling of the class based on the organizational/strategic education plan. A monthly calendar of upcoming educational events is distributed to all departments.
8. The Professional Education Department maintains education records via computer systems and hard copy files.
9. Nursing Services requires both staff and members of the nursing management team complete select educational events on an annual basis. These events are generally related to regulatory requirements for patient/employee safety and staff competency. These annual mandatory educational requirements are completed through the computer-based learning system ~~on the Hospital Intranet~~. Non-compliance with requirements invokes disciplinary action which may include termination.
10. Written participant evaluations, post-tests, and quality improvement findings are utilized to evaluate the effectiveness of educational offerings.
11. Refer to the Education Department Policy and Procedures on the TCMC Intranet for further details on specific operations.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/01	**SUBJECT: Staffing, Registry/Traveler Usage**
REVISION DATE: 3/02, 6/03, 12/03, 5/05; 5/08; 3/11; 5/14	**~~POLICY NUMBER: VIII.N~~**

Department Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	**~~05/14~~06/18**
Nursing Executive Committee Approval:	**~~05/14~~07/18**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**~~06/14~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**06/14**

A. **POLICY:**

1. Registry shall only be approved if the following criteria have been met:
   a. Managers have exhausted all available staffing resources including Per Diem, extra shifts at regular pay, overtime, and on-call staff to cover shortage.
   b. Staffing on all units has been evaluated by the Staffing Resource Coordinator, Unit Director/Manager, and Administrative Supervisor and it has been determined that all units are delivering care with the minimum staffing required for safe provision of care.
   c. Once the above have been evaluated, Registry coverage shall be considered.
      ~~c.~~**i. Overtime for registry may only be approved by the Clinical Administrator on call.**
   d. Only Registry approved for use at ~~TCMC~~**TCHD** shall be contacted.
   e. A current, signed letter of competence (LOC) must be on file before the registry person may work.
   f. Registry shall be evaluated and approved on a shift-by-shift basis, after staffing needs are determined.
   g. Registry staff that has been scheduled to work shall be cancelled at least one and half-hours before their scheduled shift if, after reassessment of staffing requirements, it is determined that they are not needed.
   h. If it is determined during the Registry assigned shift that other available resources can meet staffing needs, the remainder of the shift shall be cancelled.
      i. The registry is paid a minimum of 2 hours once confirmed to work.
2. Registry personnel are utilized at TCMC on an as needed basis.
   a. They shall follow the policies and procedures of ~~TCMC~~**TCHD**.
   b. A TCMC staff RN shall be available on the unit as a resource.
   c. A Registry nurse may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   d. The agency is responsible for Registry discipline.
   e. The following shall be maintained in the Staffing Resource Center:
      i. Letter of competence
      ii. Evaluations
      iii. Signed Cerner Access form
   f. All Registry personnel shall receive evaluations from the assigned unit at the end of the first three shifts worked, for each new specialty area worked, and quarterly. Copies of

each evaluation shall be forwarded to the appropriate Registry and a copy shall be maintained in Staffing Resource.

i. Registry personnel who receive poor evaluations require counseling by their Agency and improved performance. Failure to improve performance shall result in a Do Not Return (DNR) status for the specific unit or the Medical Center.

3. Traveler contracts shall be utilized at ~~TCMC~~ **TCHD** as needed.
   a. Traveler contracts and extensions must be approved by the Chief Nurse Executive.
   b. They shall follow the policies and procedures of ~~TCMC~~**TCHD**.
   c. A ~~TCMC~~ **TCHD** staff RN shall be available on the unit as a resource.
   d. Travelers shall be built into the regular unit schedule via the Staffing and Scheduling system.
      ~~d.~~**i. Overtime for travelers may only be approved by the Clinical Administrator on call.**
   e. A traveler RN contract may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   f. The unit manager or Assistant Nurse Manager is responsible for discipline while the traveler is on assignment. All issues shall also be forwarded to the agency.
   g. All items as outlined in the traveler contract shall be maintained in ~~Staffing~~ **Human** Resources.
   h. All travelers shall receive evaluations from the assigned unit(s) at the end of the contract.

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
District Operations

ISSUE DATE: 08/11 **SUBJECT:** Legal Documents

REVISION DATE: 10/14 **POLICY NUMBER:** 8610-294

Department Approval: ~~Review~~:	~~11/17~~05/~~18~~07/18
Administrative Policies & Procedures Committee Approval:	~~09/15~~11/~~17~~07/~~18~~08/18
Organizational Compliance Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
~~**Audit, Ethics and Compliance Committee Approval**~~	~~10/15~~
Professional Affairs Committee Approval:	n/a
Administration Approval:	08/18
Board of Directors Approval:	10/15

A. **PURPOSE:**

1. This policy enables Tri-City Healthcare District (TCHD) to comply with procedural deadlines for responding to legal documents, by ensuring TCHD is sufficiently informed of legal proceedings against it. This policy identifies the proper protocols for service of legal documents for ~~(~~TCHD~~)~~ and its employees.
2. Employees who improperly handle**, including damaging or discarding original packaging of said** legal documents, could disadvantage TCHD in legal proceedings and may be subject to discipline for violating this policy.
3. Except as provided herein, TCHD employees **or volunteers** must not accept legal documents on behalf of TCHD or any TCHD employee, physician, or independent contractor.
4. All inquiries regarding this policy shall be directed to ~~Risk Management~~**TCHD's Legal Department.**
~~4.~~**5. All envelopes must be saved with the document.**

B. **SUMMONS, COMPLAINTS, GARNISHMENTS AND SUBPOENAS:**

1. Definitions:
   a. Summons – a legal document that notifies an individual or entity that a lawsuit has commenced and the individual or entity must respond.
   b. Complaint – a legal document that sets forth the claims in a lawsuit and relief sought.
   c. Garnishment – an order issued by a court declaring that money or property (usually wages) be seized to pay a debt.
   d. Subpoena – an order issued by a court or attorney for the production of records, documents, or tangible things, or for the appearance of a person at a deposition or in court **and/or trial;**.
   e. Deposition – a proceeding in which an individual provides out of-court testimony under oath.
   ~~e.~~**f. Human Resources- Subpoena of employment records.**
   ~~f.~~**g.** Service – the process of delivering legal documents.
   ~~g.~~**h.** Process Server – an individual who serves legal documents upon a person or entity.
2. Accepting Service of Summons, Complaints, Garnishments and Subpoenas:
   a. Process Servers seeking to serve legal documents will be directed first to Security **who will escort Process Server to a TCHD's- Risk Management Department or Legal Department Designee for acceptance of Service. Designees include:**
      1. ~~TCHD General Counsel~~**Legal Department receives all subpoenas**
      ~~1.~~**2.** ~~Assistant to General Counsel~~**Risk Management Department receives all**

Complaints, Government Claims, and Notice of Intent. If Risk Management is not available, (will forward to the Legal Department)

b. Once Security is present, ~~Risk Management~~**TCHD Legal Department Designee** shall accept any ~~Summons, Complaint, Garnishment or~~ Subpoena from a Process Server on behalf of TCHD ~~or any TCHD board officer or clerk of the board in his or her official capacity (such as "Board Secretary"),~~ including Subpoenas directed to ~~"~~Persons Most Knowledgeable~~"~~ or ~~"~~Persons Most Qualified~~"~~ at TCHD.
   1. ~~Risk Management~~**Legal Department Designee** will forward Subpoenas for medical records and patient bills to the Medical Records Department.
   2. ~~Risk Management~~ **Legal Department Designee** will forward Subpoenas for employee records to Human Resources.
   3. ~~Risk Management~~**Legal Department Designee** will forward Garnishments and Subpoenas for payroll documents to the Payroll Department.
   4. **Legal Department Designee will forward Subpoenas for Human Resources.**
   ~~3.~~5. **All departments will report back to Legal Department once they have complied with the subpoena.**

c. ~~Risk Management~~ **Legal Department Designee and Security staff** shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Medical Staff, including Medical Board Subpoenas for credentialing. **Documents to be served on physicians or /Allied Health Professionals (AHP) that is not a TCHD employee. ~~shall be accepted by Medical Staff Manager.~~**

d. ~~Risk Management~~ **Legal Department Designee or Security staff** shall not accept any Summons, Complaint, Garnishment or Subpoena on behalf of the Tri-City Hospital Foundation.

e. **Legal Department and staff, and Risk Management, shall not accept any Summons, Complaint, Subpoena, or Government Claims mailed an Independent Contractor.**

~~d.~~f. **All mail or subpoena with Attention to: The Board of Directors or Tri-City Healthcare District shall be directed to CEO Executive Assistant. If she/he is not available, direct to Legal Department.**

~~e.~~g. Under no circumstances are Process Servers allowed onto patient care floors or into patient care areas for the purpose of serving Legal Documents.

~~f.~~h. In keeping with other TCHD privacy policies, TCHD employees must not provide information about other employees, physicians/**AHP** or independent contractors to Process Servers. This includes information about the employees', physicians'/**AHP's**, or independent contractors' shifts, department of employment, home address, home, cellular or office telephone number, or TCHD email address.

~~g.~~i. A Process Server who attempts service of a Summons, Complaint, Garnishment or Subpoena against an employee, physician/**AHP**, or independent contractor, or a Subpoena that requires the appearance of ~~an employee,a~~ physician/**AHP**, or independent contractor, shall be informed of TCHD's policy against the acceptance of such documents, asked to leave the premises, and escorted from the premises by Security if he or she refuses to leave voluntarily. **If necessary contact the local Police Department.**

C. ~~OTHER CLAIMS AND REQUESTS FOR INFORMATIONS~~**GOVERNMENT CLAIM(S):**

1. **After the Legal Department determines~~ng~~ whether a valid claim was brought against a public entity and whether the claim is within the specified time requirements, a claim must be presented to the public entity according to California Government Code section 915, either by delivering it to or mailing it to the: clerk, secretary, or governing body. (The secretary is defined as the Secretary of the Board of Directors).**
2. **A mailed claim is considered to be presented and received at the time and date the claim is deposited in the mail. ~~California Government Code section 915.2. Either way gives adequate notice to the public entity that a claim is being brought against it. Id.at section~~**

~~**915.4., but upon the Board of Directors only.**~~

2. ~~**Public Record Request**It is the responsibility of any person making a claim for money or damages that is not a Summons, Complaint, Garnishment or Subpoena, such as claims presented on TCHD's board-approved claim form, any other standard claim form, in a letter, or in any other document, to present such claim to the Board Clerk, Secretary of the Board or Chair of the Board per California Government Code Section 915.~~
   a. Any other TCHD employee who receives a claim for money or damages that is not a Summons, Complaint, Garnishment or Subpoena, ~~such as claims presented on TCHD's board-approved claim form, any other standard claim form, in a letter, or in any other document, shall forward such claim to Risk Management TCHD's Legal Department only. Risk Management TCHD's Legal Department shall follow the Government Code in addressing the claim.~~**shall be ~~direcred~~directed to the Legal Department.**
3. As provided in Board Policy ~~10~~14-026, only the office of the **Chief Executive Officer** (CEO) may accept requests for public records. **A Public Record Request Form shall be provided to those who wish to submit a public record request~~,~~. The requestor ~~but~~ must submit Public Record Request Form ~~attached to this policy and send~~ to the CEO. See Board Policy No. 14-026**

D. **FORM(S):**
   1. **Public Record Request Form**

E. **RELATED DOCUMENT(S):**
   ~~4.~~1. Board of Directors Policy #~~10~~14-026 – Request For Inspection of Public Records Policy
   2. **Medical Records Policy: Release of Information Pursuant to a Subpoena**
   ~~5. Patient Care Services Policy: Patient Complaints and Grievances~~
   ~~6. Public Record Request Form~~

~~D.~~F. **REFERENCE(S):**
   1. California Government Code Section 915, **California *Government Code* section 915(a)}, California *Government Code* section 915.2(a)**

TRI-CITY HEALTHCARE DISTRICT

PUBLIC RECORD REQUEST FORM

Date:_____

In accordance with Government Code section 6253(b) of the California Public Records Act, I am requesting to inspect the following documents:

_____

_____

_____

_____

I understand that the District will respond to all Public Records Requests in compliance with State law.

I am also seeking _____ copies of the documents listed above.

If I seek copies of the non-exclusive, above-listed documents, I understand that in accordance with Board Policy #026, the following non-exclusive fee schedule will apply: $.25 per page for 8 ½" x 11" copies; $.25 per page for 8½ x 14" copies; $0.25 per page for color copies; $.05 for standard business size envelope; $.10 for 9 x 12 or 10 x 13 manila envelope; postage is based on actual cost to the District, or as otherwise provided by law. Payment is required in advance of delivery of any requested records. If more than fifty (50) pages are requested, the District may require a deposit before making actual copies.

Name/Signature of Requestor: _____

Address:

_____

_____

Phone/Fax/E-Mail: _____

Refund/Additional Payment: _____

Tri-City Medical Center
Oceanside, California

Behavioral Health Services
Inpatient Behavioral Health Unit
Crisis Stabilization Unit

ISSUE DATE: 03/08

SUBJECT: Emergency Medication

REVISION DATE(S): ~~06/16~~03/13

POLICY NUMBER: 706

Department Approval:	**09/17**
Division of Psychiatry Approval:	**n/a**
Pharmacy &Therapeutics Committee Approval:	**03/18**
Medical Executive Committee Approval:	**07/18**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	

A. **DEFINITION(S):**

1. **Emergency, for this purpose, is defined 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.**

B. **PURPOSE:**

1. To ensure that patient rights related to medication administration are respected and upheld.

C. **POLICY:**

1. Involuntary patients will not be given antipsychotic medication without their informed consent unless they do not refuse the medication following disclosure of the pertinent informed consent information, there is an emergency, or a court has determined that the patient is incompetent to make an informed decision concerning medication.

D. **PROCEDURE:**

1. 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))~~.
2. 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.
3. ~~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.~~
4. ~~3.~~ 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.
5. ~~4.~~ 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.

~~6.~~5. If a patient receives emergency medication, rationale, patient response, and least restrictive measures used prior to giving medication, must be documented by the registered nurse.

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

~~7.~~1. **Behavioral Health Services Policy: Administration of Antipsychotic Medication**

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

1. **Welfare and Institutions Code Section 5332 (a)**

Tri-City Medical Center
Oceanside, California

EDUCATION DEPARTMENT ~~MANUAL~~

ISSUE DATE: 03/03 **SUBJECT:** Learning Needs Assessment

REVISION DATE(S): 07/05; 08/07; 04/10; 07/13

Department Approval:	**~~03/17~~05/18**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/22**
Board of Directors Approval:	**07/13**

A. **POLICY**

1. Needs assessment identification is the process of actively planning and implementing activities designed to solicit legitimate learning areas. Timely and consistent assessment provides direction for all educational functions and is essential for effective use of resources and cost control.
2. The needs identified for training and education are based on, as appropriate:
   a. The patient population served and the type and nature of care provided by the hospital and the department/service with age specific consideration.
   b. Individual staff member needs.
   c. Information from quality assessment and improvement activities.
   d. Needs generated by advances made in health care management and health care science and technology.
   e. Findings from department/service performance appraisals of individuals.
   ~~e.~~f. Findings from Shared Decision Making Committees.
   ~~f.~~g. Findings from review activities by peers, if appropriate.
   ~~g.~~h. Findings from the organization's plant, technology, and safety.
   ~~h.~~i. Findings from infection control activities
3. Needs assessment is an ongoing activity, which is incorporated into all internal Education Department events and external interactions with the various functions and services of the organization.
4. Through the involvement of the Education staff in the clinical setting and interaction with the leadership team in various settings, learning needs are continuously determined, prioritized and planned for.
5. ~~Each year~~**Annually** the Education Department **plans the educational opportunities based on identified needs and requests from clinical staff** ~~distributes a Learning Needs Assessment to clinical employees during the annual Skills Lab~~.
6. The results from learning needs, assessments, and performance appraisal areas for growth are computed and used for planning educational activities throughout the next year.

~~A. APPROVAL PROCESS~~

~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Professional Affairs Committee~~
~~4. Board of Directors~~

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/01

SUBJECT: Bloodborne Pathogen Exposure Control Plan

REVISION DATE: 09/02, 09/03, 09/04, 09/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/12, 10/15, 08/16~~, 6/18~~

Infection Control Department Approval:	**06~~5~~/18**
Infection Control Committee Approval:	**~~07/17~~07/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~07/18**
Professional Affairs Committee Approval:	**~~10/17~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**10/17**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

C. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

D. **AVAILABILITY TO HEALTHCARE WORKERS:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

E. **PROGRAM ADMINISTRATION:**

1. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program. In conjunction with the Infection Preventionist, she/he will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures.
2. To assist the Director of Safety/ Environment of Care (EOC) in carrying out their duties, the Environmental Health and Safety (EHSC) Committee and following specific people will be contacted as needed.
   a. Infection Preventionist
   b. Employee Health

c. Staff Educator
d. Engineering
e. Human Resources
f. Environmental Service Managers

3. Department Directors, Managers, and Supervisors are responsible for compliance in their respective areas. They work directly with the Director of Safety/EOC, the Infection Control Department, Education Department, Employee Health ~~Nurse~~ and our employees to ensure that proper exposure control procedures are followed.
   a. Managers will support activities that encourage the active involvement of employees in education and safety programs. Managers will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   c. Annually, managers will complete the template "Safer Work Practices" (see Safer Work Survey) with input from employees with respect to the procedures performed in their respective work areas or departments related to safe work practices, engineered safety devices and personal protective equipment (PPE).
   d. Managers will review quality review reports (RL Solutions) their employees complete to document **any needlestick occurrence.**~~why they did not use an available safety device.~~
      i. Managers will counsel employees who do not use safe practices, PPE, and/or safety devices.
4. The Director/Manager/**Educator for each area/unit**~~of Education and Training Services has been selected to be the facility's Education/Training Coordinator. He/she~~ is responsible for providing information and training to all employees with potential for exposure to bloodborne pathogens.~~ including:~~
   a. ~~Developing and scheduling suitable education/training programs.~~
   b. Periodically reviewing training programs with the Environment of Care Officer, Employee Health, Infection Control, and Department Managers/Supervisors to include appropriate new information.
   c. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
5. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
6. The **Product Steering Committee**~~Clinical Value Analysis Team~~ has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See ~~Clinical Value Analysis Team~~**Products Steering Committee** Product Evaluation and User Product Evaluation.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environment of Care or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
   ~~d. See Product List for a table of safety devices that have been adopted.~~
7. Employees who are determined to have occupational exposure to blood and other potentially

infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.

a. Our employees are expected to complete initial bloodborne pathogens training and annual review.
b. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).
c. Licensed healthcare professionals are required to complete a quality review report (RL Solutions) when **a needlestick injury occurs. The Director/Manager and Employee Health will investigate the occurrence.** ~~they do not use available Sharps safety devices during the care of a patient. The report will outline their determination of why using an engineering control would have jeopardized the patient's safety or the success of a medical, dental, or nursing procedure.~~
d. Employees will participate in the trial and selection of new safety devices.

8. The EHSC will compile and trend the information gathered above. August has been selected as the regular month for annual plan update.
   a. Safety rounds are conducted on an annual or as needed (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the Director of Safety/EOC or designee and reported to Environment of Care, Infection Control, and Products Standards Committees.
   c. Risk, Legal and Regulatory Services forwards information from Iincident and Quality Review Reports to the Director of Safety/EOC as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
9. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Employee Health identifies products involved in contaminated sharps injuries and reports this information to Material Management so that the number of those devices ordered in the previous year can be reported to the EHSC.
   e. Recommendations are made to the **Supply Chain Management** ~~Product Standardization Committee~~ when a need for a safety device or alternative product is detected.
   f. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   g. Employee Health will present sharps Injury data specific to TCHD at the Infection Control

Committee meeting annually (i.e. safety devices, work practice changes or engineering).

F. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which employees may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., employees are considered to be exposed even if they wear personal protective equipment).
2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some employees handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.
3. Since not all of the employees in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these employees to have occupational exposure are listed in Potential Blood Exposure by Job Category.

G. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize employee exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying employees with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   ~~e. See the table on Product List for a review of the Sharps Safety Devices that have been adopted.~~
   ~~f.~~**e.** Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   ~~g.~~**f.** Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant,

portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily

iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.

iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.

~~h.~~**g.** In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.

i. Hand washing facilities and waterless hand cleansers are readily accessible to employees with potential for exposure.

ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.

iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

H. WORK PRACTICE CONTROLS:

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize employee exposure to bloodborne pathogens.

a. Employees follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:

i. Semen
ii. Vaginal Secretions
iii. Peritoneal fluid
iv. Tissue and Organs
v. Amniotic fluid
vi. Synovial fluid
vii. Pleural fluid
viii. Saliva with visible blood
ix. Pericardial fluid
x. Cerebrospinal fluid

b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.

i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.

ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.

c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.

d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.

e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.

i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.

ii. Information regarding the contamination is conveyed to all affected employees, the equipment manufacturer, and the equipment service representative.

I. **PERSONAL PROTECTIVE EQUIPMENT (PPE):**

1. **PPE is t**~~T~~he employee's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our employees) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:
   a. Gloves
   b. Fluid resistant gowns
   c. Glove liners
   d. Laboratory coats
   e. Face shield
   f. Resuscitation bags
   g. Masks
   h. Hoods
   i. Safety glasses/goggles
   j. Shoe covers
   k. Mouthpieces
   l. Pocket masks
2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to employees who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

J. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All employees are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or

other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.

c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.

d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.

4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual Section 6: Hazard Material Management: Waste Management Policy.
   a. See TCMC Waste Disposal Guidelines.
5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides should hold the bags away from their bodies when removing waste. During removal, use heavy gloves to protect their hands from possible sharps injury, and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Employees who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

K. **FORM(S):**

1. Safer Work Survey
2. ~~Clinical Value Analysis Team~~**Products Steering Committee** Product Evaluation
3. User Product Evaluation
4. ~~Product List~~
5. ~~4.~~ Potential Blood Exposure by Job Category
6. ~~5.~~ Standard Precautions – Personal Protective Equipment

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

1. Employee Health and Wellness Policy: Injury and Illness Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care **Policy** ~~Manual~~: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: ~~Hazardous~~ Waste Management
5. Infection Control **Procedure**~~Manual~~: Hand Hygiene
6. Infection Control **Policy**~~Manual~~: Standard and Transmission Based Precautions
7. TCMC Waste Disposal Guidelines

M. **REFERENCES:**

1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. https://www.dir.ca.gov/title8/5193.html
2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2000 www.cadhs.gov
3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
4. Wenzel, RP & Nettleman, MD, Principles of Hospital Epidemiology in: Mayhall G. ed. Hospital Epidemiology and Infection Control. 2nd ed. Philadelphia: Lippincott, Williams & Wilkins; 1999:1357 - 1366.
5. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf

TRI-CITY HEALTHCARE DISTRICT
SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

~~Clinical Value Analysis Team~~Products Steering Committee Product Evaluation

1. Manufacturer of Product_____
2. Name of Product_____
3. Distributed by_____Sales Rep_____
4. Description of Use_____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace?_____
8. Cost _____Standard item cost_____
9. Has TCHD rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No

_____

14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify:_____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS_____

_____

_____

_____

User Product Evaluation

Name_____ Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

_____

_____

_____

POTENTIAL BLOOD EXPOSURE BY JOB CATEGORY

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist Histology Lab Tech	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

Standard Precautions
Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • Angiograph catheter • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • Intravascular catheters • Thoracentesis • Urine catheter	*			*				*			*			*	
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*				*			*			*				*
Bronchoscopy	*			N95				*			*				*
Bronchoscopy (R/O TB)	*			PAPR				*			*				*
Central venous catheter insertion	*				*			*			*				*
Chest tube/vent placement	*				*			*			*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*				*				*
Intubation	*			*				*			*				*
L.P. (holding R/O meningitis)	*			*				*			*				*
Morgue Release	*					*			*						*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			*				*			*			*	
Assisting with Surgery														*	
Thoracentesis ass.	*				*			*			*				*
SPECIMEN COLLECTION															
ABG	*				*			*			*				*
Blood glucose test	*				*			*			*				*
Clean catch urine specimen	*				*			*			*				*
Dipstick urine test	*				*			*			*				*
Gastric occult. blood test	*			*				*			*				*
Nose/throat (R/O infection)	*			*				*			*				*
Sputum for AFB or TB culture	*			N95				*			*				*
Stool	*				*			*			*				*
Stool occult blood test	*				*			*			*				*
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*
SPECIMEN PROCESSING	*			per S.O			Lab coat								

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*				*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB	*			N95				*				*			*
Sputum Induction for AFB R/O tuberculosis	*			PAPR				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

DELETE – do not need policy with definitions, content in Infection Control Policy: Risk Assessment and Surveillance Plan

SUBJECT: Healthcare Associated Infections, Defined **POLICY NUMBER: IC. 4**

ISSUE DATE: 9/2001
REVISED: 9/03, 10/06, 4/10, 05/15

Department Approval Date(s):	~~04/14~~04/18
Infection Control Committee Approval Date(s):	~~04/14~~04/18
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Professional Affairs Committee Approval Date(s):	~~05/15~~n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	05/15

~~A. **DEFINITION(S):**~~

~~1. The Hospital Infections Program, Center for Infectious Diseases, CDC, developed a set of definitions for surveillance of healthcare associated infections (HAI). The definitions were introduced into hospitals participating in the National Nosocomial Infections study (NNIS) in 1987, and modified by the National Healthcare Safety Network (NHSN) in 2006. There have been modifications based on comments from infection control personnel to reflect changes in medical technology. The following are the current definitions for healthcare associated infections used by the CDC NHSN. By adopting these criteria, we are able to compare our infection rates with national data.~~

~~a. The NHSN definitions defined below are updated at least annually by CDC; therefore the definitions outlined below may not be the most current definitions. Infection control department always uses the current definitions outlined by NHSN to determine a HAI.~~

~~2. For an infection to be defined as a HAI, there must be no evidence that the infection was present or incubating at the time of hospital admission. An infection that is associated with hospital care and becomes evident after hospital discharge may also be considered healthcare acquired according the criteria. Infections that are associated with a complication or extension of infection(s) already present on admission, unless a change in pathogen or symptoms strongly suggest that acquisition of a new infection are considered community acquired. Infection in an infant that is known or proved to have been acquired transplacentally (e.g., herpes simplex, rubella, or syphilis) and becomes evident shortly after birth will not be considered to be acquired in the facility.~~

~~3. Surgical Site Infections – *CRITERIA* for defining a Surgical Site Infection (SSI)~~

~~a. Superficial Incisional SSI~~

~~b. Infection occurs within 30 days after the operation **and**~~

~~c. Infection involves only skin or subcutaneous tissue of the incision **and**~~

~~d. At least *one* of the following:~~

~~i. Purulent drainage, with or without laboratory confirmation, from the superficial incision.~~

~~ii. Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.~~

~~iii. At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat *and* superficial incision is deliberately opened by surgeon, *unless* incision is culture negative.~~

~~iv. Diagnosis of superficial incisional SSI by the surgeon or attending physician.~~

~~e. Do *not* report the following conditions as SSI:~~

i. Stitch abscess (minimal inflammation & discharge confined to the points of suture penetration).
ii. Infection of an episiotomy or newborn circumcision site.
iii. Infected burn wound.
iv. Incisional SSI that extends into the fascial and muscle layers (see deep incisional SSI).
v. *Note:* Specific criteria are used for identifying infected episiotomy and circumcision sites and burn wounds. Not included in this indicator.

4. Deep Incisional SSI
   a. Infection occurs within 30 or 90 days after the operation (where day 1= the procedure date) **and**
   b. Infection involves deep soft tissues (e.g., fascial and muscle layers) of the incision **and**
   c. At least *one of* the following:
      i. Purulent drainage from the deep incision but not from the organ/space component of the surgical site.
      ii. A deep incision spontaneously dehisces or is deliberately opened by a surgeon when the patient has at least one of the following signs or symptoms: fever (greater than 38ºC), localized pain, or tenderness, unless site is culture-negative.
      iii. An abscess or other evidence of infection involving the deep incision is found on direct examination, during re-operation, or by histopathologic or radiologic examination.
   d. Notes:
      i. Report infection that involves both superficial and deep incision sites as deep incisional SSI.
      ii. Report an organ/space SSI that drains through the incision as a deep incisional SSI.

5. Organ/Space SSI
   a. Infection occurs within 30 or 90 days after the operation (where day 1= the procedure date) **and**
   b. Infection involves any part of the anatomy (e.g., organs or spaces), other than the incision, which was opened or manipulated during an operation **and**
   c. At least *one* of the following:
      i. Purulent drainage from a drain that is placed into the organ/space.
      ii. Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
      iii. An abscess or other evidence of infection involving the organ/space that is found on direct examination, during re-operation, or by histopathologic or radiologic examination **and**
      iv. Meets at least one criterion for a specific organ/space infection site according to NHSN surveillance definitions.

6. Ventilator Associated Events - Intensive Care Unit
   a. Ventilator-Associated Condition (VAC)
      i. Patient has a baseline period of stability or improvement on the ventilator, defined by greater than or equal to (≥) 2 calendar days of stable or decreasing daily minimum FiO2 or PEEP values. **and**
      ii. After a period of stability or improvement on the ventilator, the patient has at least one of the following indicators of worsening oxygenation:
         1) Increase in daily minimum FiO2 of greater than or equal to (≥) 0.20 (20 points) over the daily minimum FiO2 in the baseline period, sustained for greater than or equal to (≥) 2 calendar days.
         2) Increase in daily minimum PEEP values of greater than or equal to (≥) 3 cmH2O over the daily minimum PEEP in the baseline period, sustained for greater than or equal to (≥) 2 calendar days.
         3) Note:

a) Daily minimum defined by lowest value of FiO2 or PEEP during a calendar day that is maintained for at least 1 hour.
b) FiO2 or PEEP values. The baseline period is defined as the two calendar days immediately preceding the first day of increased daily minimum PEEP or FiO2.

b. Infection-related Ventilator-Associated Complication (IVAC)
i. Patient meets criteria for VAC **and**
ii. On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, the patient meets both of the following criteria:
1) Temperature greater than (>) 38 °C or less than (<) 36°C, OR white blood cell count greater than or equal to (≥) 12,000 cells/mm3 or less than or equal (≤) 4,000 cells/mm3.
2) A new antimicrobial agent(s)* is started, and is continued for greater than or equal to (≥) 4 calendar days.

c. Possible Ventilator-Associated Pneumonia VAP
i. Patient meets criteria for VAC and IVAC **and**
ii. On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, one of the following criteria is met:
1) Purulent respiratory secretions (from one or more specimen collections)
a) Defined as secretions from the lungs, bronchi, or trachea that contains greater than (>) 25 neutrophils and less than (<) 10 squamous epithelial cells per low power field [lpf, x100].
b) If the laboratory reports semi-quantitative results, those results must be equivalent to the above quantitative thresholds.
c) See additional instructions for using the purulent respiratory secretions criterion in the VAE Protocol.
2) Positive culture (qualitative, semi-quantitative or quantitative) of sputum
a) Endotracheal aspirate
b) Bronchoalveolar lavage
c) Lung tissue, or protected specimen brushing
iii. Excludes the following:
1) Normal respiratory/oral flora, mixed respiratory/oral flora or equivalent
2) Candida species or yeast not otherwise specified
3) Coagulase-negative Staphylococcus species
4) Enterococcus species

d. Probable Ventilator-Associated Pneumonia VAP
i. Patient meets criteria for VAC and IVAC
ii. And
iii. On or after calendar day 3 of mechanical ventilation and within 2 calendar days before or after the onset of worsening oxygenation, ONE of the following criteria is met:
1) Purulent respiratory secretions (from one or more specimen collections and defined as for possible VAP) and one of the following:
a) Positive culture of endotracheal aspirate, greater than or equal to (≥) 10^6 CFU/ml or equivalent semi-quantitative result
b) Positive culture of bronchoalveolar lavage, greater than or equal to (≥) 10^4 CFU/ml or equivalent semi-quantitative result
c) Positive culture of lung tissue, greater than or equal to (≥) 104CFU/g or equivalent semi-quantitative result
d) Positive culture of protected specimen brush*, greater than or equal to (≥) 103CFU/ml or equivalent semi-quantitative result
e) Same organism exclusions as noted for Possible VAP.

2) One of the following (without requirement for purulent respiratory secretions):
   a) Positive pleural fluid culture (where specimen was obtained during thoracentesis or initial placement of chest tube and NOT from an indwelling chest tube)
   b) Positive lung histopathology
   c) Positive diagnostic test for Legionellaspp.
   d) Positive diagnostic test on respiratory secretions for influenza virus, respiratory syncytial virus, adenovirus, parainfluenza virus, rhinovirus, human metapneumovirus, coronavirus

7. Primary Bloodstream Infections (BSI) related to Central Lines – Intensive Care Units
   a. Catheter-Associated BSI
      i. Vascular access device that terminates at or close to the heart or one of the great vessels. An umbilical artery or vein catheter is considered a central line.
      ii. BSI is considered to be associated with a central line if the line was in place and accessed greater than (>) 2 calendar days before development of the BSI.
8. Urinary Tract Infections (UTI), device related
   a. Catheter- Associated UTI
      i. A UTI where an indwelling urinary catheter was in place for greater than (>) 2 days on the day of the infection, with day of device placement being Day 1, *and* an indwelling urinary catheter was in place on the day of the infection or the day before. If an indwelling urinary catheter was in place for greater than (>) 2 days and then removed, the UTI criteria must be fully met on the day the device was discontinued or the next day.
9. Home Care
   a. The CDC Definitions do not contain criteria related to home care acquired infections. The Association for Professionals in Infection Control and Epidemiology has written guidelines to address the different practice setting and we have adopted these definitions (see home care policy).

B. **REFERENCES:**

1. National Healthcare Safety Network (NHSN) Surveillance Definitions for Specific Types of Infections January 2014 www.cdc.gov/nhsn/PDFs/pscManual/17pscNosInfDef_current.pdf
2. Centers for Disease Control and Prevention. Guidelines for the Prevention of Intravascular Catheter-Related Infections. MMWR 2011 http://www.cdc.gov/hicpac/pdf/guidelines/bsi-guidelines-2011.pdf

C. **RELATED DOCUMENTS**

1. Infection Control Philosophy IC.1
2. Infection Control Surveillance Program IC.2
3. Infection Control Epidemiologic Investigation of a Suspected Outbreak IC.3

INFECTIOUS DISEASES OF CONCERN TO THE PREGNANT EMPLOYEE IC. 5.2

DELETE – incorporated into Infection Control Policy: Standard Precautions.
Department Approval: 04/18
Infection Control Committee Approval: 04/18
Medical Executive Committee Approval: 07/18
Professional Affairs Committee Approval: n/a
Administration: 08/18
Board of Directors Approval:

The nonimmune health care worker (pregnant or not) should not care for patients with:

1. Rubella = German Measles
2. Rubeola = Measles
3. Varicella Zoster = Chickenpox or herpes zoster = shingles

Disease	*Infective Material*	*Transmission*	*A*	
AIDS	Blood or body fluid containing blood Cerebrospinal fluid Synovial, pleural, peritoneal, pericardial, & amniotic fluid Vaginal secretions and Semen	Parenteral (needlesticks) Mucous membrane Non-intact skin	None use Standard Precautions.	No
Cytomegalovirus (CMV)	Urine Respiratory secretions Possible other body fluids	Close intimate contact	Add mask if CMV pneumonia & use Standard Precautions. If children at home attend day care center, good hand washing at home	No
Hepatitis A	Feces	Fecal-oral	None use Standard Precautions.	No
Hepatitis B	Blood	Parenteral Mucous membrane Non-intact skin	None use Standard Precautions. Immune with hepatitis B vaccine	No
Hepatitis C	Blood	As above	None use Standard Precautions.	No
Herpes simplex types I and II	Lesions	Direct contact with lesions Or respiratory secretions and saliva	None use Standard Precautions. Avoid direct contact with lesions. Double glove.	No
Herpes zoster (shingles) • Localized	Open, weeping lesions	Direct contact	If immune, use Standard Precautions.	Nonimmune health care workers should not have patient contact.
Herpes zoster (shingles) • Disseminated	Lesions, possibly respiratory secretions	Direct contact Airborne	If immune, use Standard Precautions.	Same as above
Listeriosis	Contaminated foods	Ingestion	None use Standard Precautions.	No
Multi-Drug Resistant Bacteria (VRE or MRSA)	Colonized or infected patients or contaminated devices, environmental surfaces or equipment.	Contact	Use Contact Precautions	No
Rubella (German Measles)	Respiratory secretions	Droplet	If immune, use Standard Precautions. Immunization available for nonpregnant worker.	Nonimmune health care workers should not have patient contact.
Rubeola (Measles)	Respiratory secretions	Airborne	If immune, use Standard Precautions. Immunization available for nonpregnant worker.	Nonimmune health care workers should not have patient contact.
Toxoplasmosis	Cat feces Raw meat Unpasteurized milk	Ingestion	None	No
Tuberculosis	Airborne bacteria	Airborne	Airborne Precautions. N95 respirator required by OSHA for HCW.	No
Varicella zoster (chickenpox)	Respiratory secretions Lesion secretions	Airborne Contact with fluid from lesions	If immune, use Standard Precautions.	Nonimmune health care workers should not have patient contact.

Agent	Potential Effect on Fetus	Rate of Perinatal Transmission	Maternal Screening	Prevention
Cytomegalovirus virus	Hearing loss; congenital syndrome*	15% after primary maternal infection; symptomatic 5% Transmission from pts to HCW has never been documented. 50% of the US pop. carries antibodies to CMV.	Antibody provides some but not complete protection against clinical disease; routine screening not recommended	Standard Precautions
Hepatitis B	Hepatitis; development of chronic infection in infant	HBeAg seropositive 90%; HBeAg negative 0-25%	HBsAg routine screening recommended	Vaccine and HBIG to infant; standard precautions
Hepatitis C	Hepatitis	2-5%	Anti-HCV; HCV RNA in reference labs; routine screening not recommended	Standard Precautions
Herpes simplex	Mucocutaneous lesions, sepsis, encephalitis; congenital malformations (rare)	Unlikely from nosocomial exposure; primary infection rates = 33-50% and recurrent = 4%	Antibody testing not useful; inspection for lesions at delivery	Standard Precautions
Human immuno-deficiency virus	AIDS by 2-3 yr	8-30%	Antibody by enzyme immunoassay, Western blot	Avoid high-risk behaviors; consider post exposure prophylaxis after high-risk needle stick exposure; intrapartum and postnatal zidovudine for HIV-seropositive mothers and their babies; Standard Precautions
Influenza	Inconsistent	Rare	None	Vaccine (safe during pregnancy); Droplet precautions
Measles	Prematurity; abortion	Rare	History, antibody	Vaccine†; Airborne precautions
Parvovirus B19	Hydrops, stillbirth	Rare, 3-9% maximum adverse outcome	IgM and IgG antibody prepregnancy; antibody protective	Droplet precautions
Rubella	Congenital syndrome*	45-50% overall; 90% in 1st 12 weeks	Antibody	Vaccine†; Droplet precautions for acute infection; Contact precautions for congenital rubella
Tuberculosis	Hepatomegaly, pulmonary, CNS	Rare	Skin test	Isoniazid ± ethambutol for disease; Airborne precautions
Varicella zoster (Chikenpox)	Malformations (skin, limb, CNS, eye)	Total 25%; congenital syndrome (0-4%) 95% of adults already exposed.	Antibody	Vaccine†; VZIG within 96 hours of exposure if susceptible; Airborne and Contact precautions

HbeAg, Hepatitis B e antigen; CNS, central nervous system

*Congenital syndrome: varying combinations of jaundice, hepatosplenomegaly, microcephaly, CNS abnormalities, thrombocytopenia, anemia, retinopathy, and skin and bone lesions.

†Live virus vaccines are given routinely before pregnancy.

"Guideline for Infection Control in Health Care Personnel, 1998," U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1998.

Disease	*Risk to Fetus*
AIDS	25-30 percent of infants born to HIV-infected mothers are infected before, during, or shortly after birth.
Cytomegalovirus (CMV)	Fetal infections may occur during either primary or reactivated maternal infections. Neonatal CMV infections occur in 0.3-1 percent of births; most are unapparent. Infection results in central nervous system involvement, chronic birth diseases, or death in utero in 5-10 percent of infected infants.
Hepatitis A	Possible neonatal hepatitis.
Hepatitis B	Perinatal infection has a high likelihood of chronic hepatitis, cirrhosis, or primary hepatocellular carcinoma.
Herpes simplex types I and II	Vaginal delivery in pregnant women with active genital infections carries a high risk of infection to fetus or newborn, causing disseminated infection, encephalitis, and death.
Listeriosis	Listeria infections during pregnancy may cause an influenza-like illness with fev3er and chills, and may lead to loss of the fetus.
Rubella (German measles) and Rubeola (measles)	Congenital rubella syndrome occurs in ≥ 25 percent of infants born to women who acquired rubella during first trimester of pregnancy. Risk falls to 10-20 percent by 16th week and defects are rare when maternal infections occur after 20th week of gestation. Fetuses infected early are at greatest risk of intrauterine death, spontaneous abortions, congenital malformations of major organ systems. Increased abortion rate.
Toxoplasmosis	A primary infection during early pregnancy may lead to fetal infection with death of fetus or chorioretinitis, brain damage, hydrocephaly, or microcephaly.
Varicella zoster (chicken pox) Herpes zoster (shingles)	Infections early in pregnancy may rarely be associated with congenital malformations. Infants born to mothers who develop the disease five days prior or two days after delivery are at increased risk of developing severe generalized chicken pox, with a case fatality rate of up to 30 percent.

References

Centers for Disease Control and Prevention, Guideline for Isolation Precautions in Hospitals. Infect Control Hosp Epidemiol 1996; 17:53-80

Amori, G. Isolation Systems in: APIC Text of Infection Control and Epidemiology. Washington DC;2000:15.1-8.

Tri-City Medical Center
Oceanside, California

LABORATORY
GEN LAB QA

ISSUE DATE: NEW **SUBJECT: Individualized Quality Control Plan**

REVISION DATE(S):

Department Approval:	**06/18**
Laboratory Director Approval:	**07/18**
Department of Pathology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	

A. **DEFINITION(S):**

1. Individualized Quality Control Plan (IQCP) – a framework for customizing a quality control program for the test systems in each laboratory's unique environment.
2. Risk Assessment (RA) – the process of identifying and evaluating the potential failures and errors that could occur during the pre-analytical (before testing), analytical (testing), and post-analytical (after testing) phases of testing.
3. Quality Control Plan (QCP) – describes practices, procedures and resources needed by the laboratory to ensure the quality of a testing process. The QCP includes measures to assure the accuracy and reliability of test results, and that the quality of testing is adequate for patient care.
4. Quality Assessment (QA) – the implementation of policies and procedures to monitor and assess, and when indicated, correct problems identified related to test performance,
5. College of American Pathologists (CAP) – a member-based physician organization advocating best practices in pathology and laboratory medicine and provides accreditation of laboratories under deemed authority by CMS and CDPH.

B. **POLICY:**

1. The laboratory has identified all tests using an IQCP on the List of Individualized Quality Control Plans form provided by the College of American Pathologists. (COM.50200)
   a. Note: The use of the CAP form is required, even if standardized forms and templates are used by the laboratory. The laboratory is responsible for maintaining the accuracy of the data on the form and for providing a current copy to the inspector during an on-site CAP inspection.
2. The IQCP for a test, device, or instrument includes a risk assessment to evaluate potential sources of error. The risk assessment should include the following attributes. (COM.50300)
   a. Pre-analytic, analytic, and post-analytic phases of the testing process
   b. Intended medical uses of the test and impact if inaccurate results are reported (clinical risk)
   c. Components of the tests including reagents, environment, specimen, testing personnel, and test system
   d. Variations in the components based on use of the tests (e.g. use in different environments, by different personnel, or multiple identical devices)
   e. Data from the laboratory's own environment, instrument/equipment performance, and testing personnel demonstrating acceptable performance over the maximum time interval between external quality control runs defined in the IQCP
   f. Manufacturer's instructions and recommendations

g. The process used to identify the sources of potential failures and errors for a test system, and evaluate frequency and impact of those failures and sources of error.

3. The IQCP includes a written quality control plan approved by the laboratory director prior to implementation. (COM.50400)
   a. NOTE: The quality control plan may be part of a test procedure or be a separate written plan.
4. The IQCP must define all aspects monitored based on the potential errors identified during the risk assessment, including the following parameters as applicable. (COM.50500)
   a. The number, type (external and internal quality control systems), and frequency of quality control
   b. Criteria for acceptable performance
   c. Monitoring of the testing environment and reagents
   d. Specimen quality
   e. Instrument calibration, maintenance, and function checks
   f. Training and competency of testing personnel
   g. Provisions for multiple identical devices and variation for uses covered under one IQCP
5. The components of the quality control plan must meet regulatory and CAP accreditation requirements and be in compliance with the manufacturer instructions, at minimum. The quality control plan must control the quality of the test process and ensure accurate and reliable test results.
6. External control material samples must be analyzed with new lots and shipments of reagents or more frequently if indicated in the manufacturer's instructions.
7. Ongoing quality assessment monitoring is performed by the laboratory to ensure that the quality control plan is effective in mitigating the identified risks for the IQCP and includes the following records. (COM.50600)
   a. Review of quality control and instrument/equipment maintenance and function check data at least monthly
   b. Evaluation of errors relating to pre-analytic, analytic and post analytic phases of the testing process
   c. Review of complaints from clinicians and other healthcare providers regarding the quality of testing to confirm the clinical efficacy of testing
   d. Evaluation of corrective actions taken if problems are identified
   e. Re-evaluation of the quality control plan if changes to the reagents, environment, specimen, testing personnel, or test system elements of the risk assessment occur
   f. Re-approval of the quality control plan by the laboratory director or designee at least annually
   g. NOTE: If ongoing assessments identify failures in one or more components of the quality control plan, the laboratory must investigate the cause and consider if modifications are needed to the quality control plan to mitigate potential risk.

C. **PROCEDURE:**
1. Use the Eligibility Determination for Individualized Quality Control Plan (IQCP) Option to determine if the test, device, or instrument is eligible for an IQCP.
2. Complete a risk assessment in accordance with this policy.
3. Develop and document the quality control plan for the test, device, or instrument based upon the risk assessment and in accordance with this policy.
4. Review the IQCP with the laboratory director and obtain approval prior to implementation.
5. Complete ongoing quality assessment monitoring as part of regular quality assurance activities.
6. Document, at least annually, the effectiveness of the IQCP on the Annual Assessment of Individualized Quality Control Plan Form.

D. **FORM(S):**
1. Annual Assessment of Individualized Quality Control Plan Form
2. List of Individualized Quality Control Plans Form

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

1. Eligibility Determination for Individualized Quality Control Plan (IQCP) Option

F. **REFERENCES:**

1. Department of Health and Human Services. (2014). Considerations When Deciding to Develop an IQCP [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIAbrochure12.pdf
2. Department of Health and Human Services. (2014). What is an IQCP? [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIAbrochure13.pdf
3. Department of Health and Human Services. (2014). Developing an IQCP - A Step-by-Step Guide [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/IQCP-Workbook.pdf
4. College of American Pathologists. Laboratory All Common Checklist. Northfield, IL, 2017.

Tri-City Medical Center

Annual Assessment of Individualized Quality Control Plan (IQCP)

Laboratory Section/Department:	Instrument/Device/Tests:	Date:

Quality Control Plan Questionnaire

Provide additional comments, if necessary, in the comment section.

1. Have any new test process failures been identified?	☐ YES ☐ NO
a. Assess the use (e.g. timely, effective) of the monthly review process of quality control, temperature, and maintenance logs to identify problems.	☐ Completed
b. Record any corrective action for patient results affected by the testing process failure.	☐ Completed ☐ N/A
c. Evaluate the effectiveness of the corrective action taken.	☐ Completed ☐ N/A
2. Have any changes been made to the five elements of the Risk Assessment (i.e. reagents, environment, specimen, testing personnel, or test system) requiring reevaluation of the Quality Control Plan?	☐ YES ☐ NO
3. Have any changes been made to the Quality Control Plan?	☐ YES ☐ NO
a. Specify any updates/modifications below	
4. Have revisions to the Quality Control Plan been signed by the laboratory director (including signature and date)?	☐ YES ☐ NO ☐ N/A
5. Is the IQCP sufficient to mitigate risk in this laboratory? If no, explain actions to be taken.	☐ YES ☐ NO

Comments: _____

_____

_____

_____

_____

_____

_____

Based upon the performance of the quality assessment monitors in place, the IQCP for this test system is effective in mitigating the identified risks and is reapproved for continued utilization.

Laboratory Director or Designee Signature: _____ Date: _____

Tri-City Medical Center

Summary of Quality Assessment Monitoring

QA Process/Monitor	*Completed or Reviewed Appropriately?*	*Issues Identified*	*Corrective Actions Taken*
Quality Control performed appropriately and reviewed monthly	☐ YES ☐ NO		
Temperature logs completed and reviewed monthly	☐ YES ☐ NO		
Maintenance logs completed and reviewed monthly	☐ YES ☐ NO ☐ N/A		
Instrument issues resolved and recorded	☐ YES ☐ NO		
Proficiency testing performed and reviewed	☐ YES ☐ NO		
Sampling of personnel training/competency reviewed	☐ YES ☐ NO		
Sampling of patient results reviewed	☐ YES ☐ NO		
Relevant quality indicators reviewed	☐ YES ☐ NO		
Laboratory occurrence reports reviewed	☐ YES ☐ NO ☐ N/A		
Complaint reports reviewed	☐ YES ☐ NO ☐ N/A		

COLLEGE of AMERICAN PATHOLOGISTS

List of Individualized Quality Control Plans

Laboratories: Complete the fields below for each IQCP in use and present to the inspector during the on-site inspection. Laboratories with different CAP and/or CLIA numbers must complete separate forms.
Inspectors: Refer to Inspector Instructions in the IQCP section of the All Common Checklist for instructions on identifying a sampling of IQCP records to review in detail.

Laboratory Name:	Tri-City Medical Center	CAP Number:	2317601

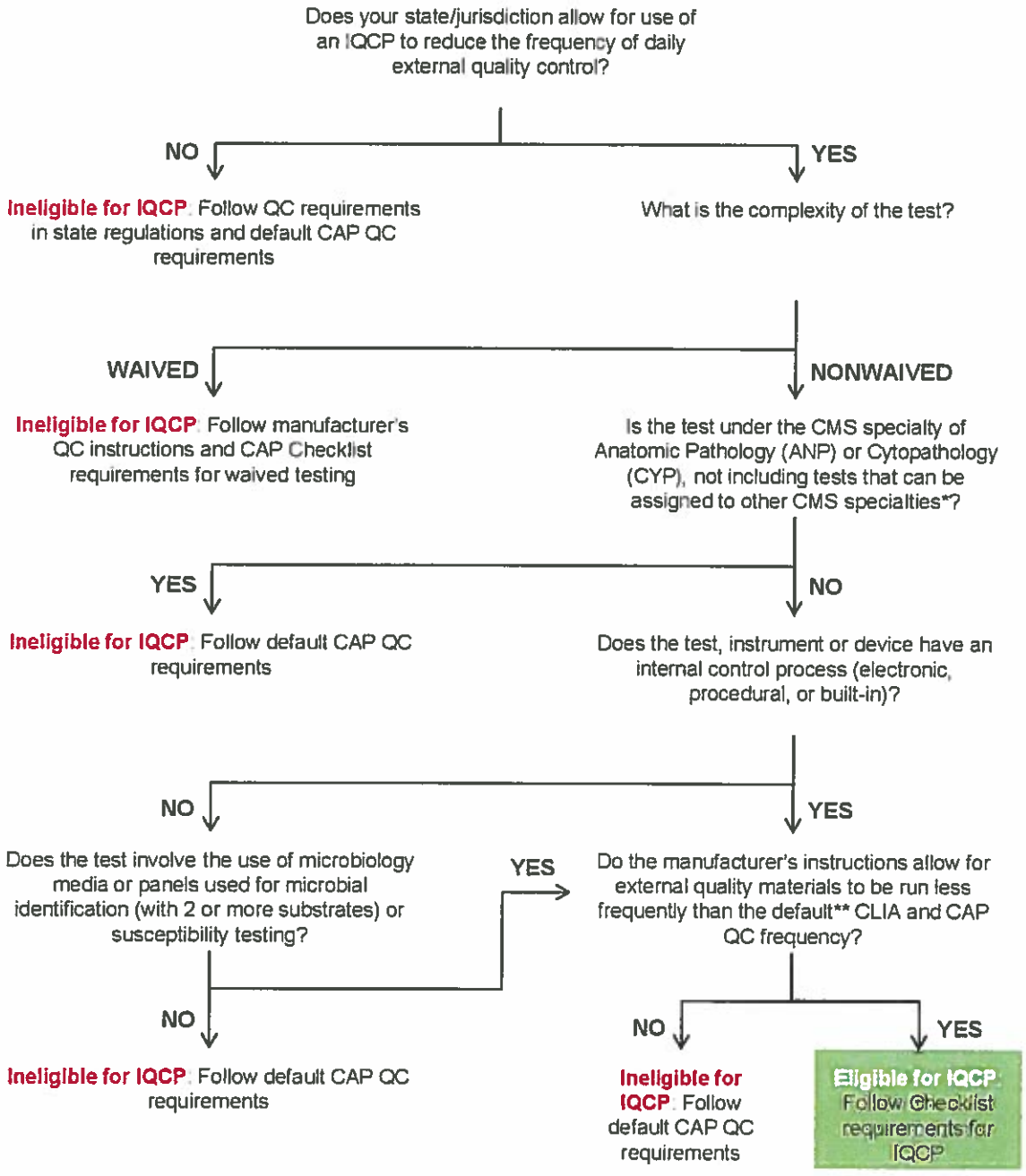
Laboratory Section/ Department	Instrument/Device Include name, manufacturer, model, and number of instruments (if applicable)	Tests List all tests included under the IQCP	Test Sites If used in more than one area	Implementation/ Revision Date

COLLEGE of AMERICAN PATHOLOGISTS

Laboratory Section/ Department	Instrument/Device Include name, manufacturer, model, and number of instruments (if applicable)	Tests List all tests included under the IQCP	Test Sites If used in more than one area	Implementation/ Revision Date

COLLEGE of AMERICAN PATHOLOGISTS

Eligibility Determination for Individualized Quality Control Plan (IQCP) Option



* ANP or CYP tests are ineligible for IQCP unless the testing can be billed under another CMS specialty.
** The default CAP QC frequency for external quality control materials is as follows:

1) Quantitative tests - two controls at different concentrations each day of patient testing, except for Coagulation tests (two levels every eight hours) and Blood Gas testing (one level every eight hours)
2) Qualitative tests – positive and negative controls each day of patient testing.

IQCPE 4.0
FEBRUARY 2016

Tri-City Medical Center
Oceanside, California

Mammography Women's Center
~~Diagnostics, Imaging & Therapeutics Policies & P~~

DELETE – follow Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396 and Patient Care Services Policy: Patient Complaints & Grievances

ISSUE DATE: 01/00 **SUBJECT:** Consumer Complaint

REVISION DATE(S): 11/01

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/11

~~A. DEFINITIONS:~~

~~1. Consumer: Patient or patient's advocate, or representative such as a family member or physician.~~

~~2. Serious Complaint: Any complaint dealing with a clinical outcome that was compromised by the facility such as:~~

~~a. Poor image quality~~

~~b. Use of personnel that do not meet qualification requirements~~

~~c. Failure ofresults to be received in specified time frames.~~

~~d. Failure to correct any of the above.~~

~~3. Adverse event: Failure to report results~~

~~4. Serious adverse event: False negative interpretations~~

~~B. PURPOSE:~~

~~1. To ensure a method for consumer complaints that meets regulatory guidelines.~~

~~C. POLICY:~~

~~1. Consumer complaints will be completed on Quality Review Forms and processed via the TCMC Quality Resource Services department. Each complaint will be hand addressed, resolved. Appropriate actions will be taken in an expeditious manner.~~

~~D. PROCEDURE:~~

~~1. A record of any complaint (see Flowchart) will be held for three (3) years. Unresolved complaints warrant notification to the consumer (with adequate directions for filing the complaint with the accrediting body) and notification of accrediting body by the facility within 30 days.~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: NEW

SUBJECT: Enhancing Quality using the Inspection Program (EQUIP)

REVISION DATE(S):

Department Approval:	**03/18**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	

A. **PURPOSE:**

1. To Enhance facilities to continue providing Quality mammography using the Inspection Process Purpose:
2. To promote clinical image quality as a primary goal of the Mammography Quality Standards Act (MQSA) required by FDA policy:
   a. 900.12(i)Clinical images produced by any certified facility must continue to comply with the standards for clinical image quality established by that facility's accreditation body.
   b. 900.12(d)(1)(ii)(A)All interpreting physicians shall follow the facility procedures corrective action when the images they are asked to interpret are of poor quality.
   c. 900.12(d)(2) Quality assurance records. The lead interpreting physician… shall ensure that records concerning mammography technique and procedures, quality control (including monitoring data, problems detected by analysis of that data, corrective actions, and the effectiveness of the corrective actions), safety, protection and employee qualifications to meet assigned quality assurance tasks are properly maintained and updated.

B. **PROCEDURE:**

1. Quality Assurance- Clinical Image Corrective Action:
   a. To comply with MQSA requirements, mammography department has established a mechanism to continue providing quality images indicating that interpreting physicians (IPs) are required to follow department's procedures for corrective action when the images they are reviewed by IPs, are of poor quality.
   b. Mammography facility's interpreting physicians (IPs) randomly auditing mammography technologists' performances on positioning, quality of images, techniques and other necessary requirements for quality assurance (QA) purposes. Mammography department has displayed a review comment sheets for IPs to document their comments for each individual mammography technologist. IPs will document their comments on designated areas for positioning, compression, exposure level, contrast, sharpness, noise , artifacts, and exam identification. If an area of inefficiency is located, steps to correct the deficiency will be taken. In addition, recommendations on how to improve problem/problems will be discussed with technologists in order to enhance clinical image quality as well as increasing expertise of staff.
   c. Additional Recommendations" and "Additional Comments" on the second page that is followed by technologist's signature indicating that corrective action will be followed by IP reviewer and technologist. Patient will be called back for repeating the exam if there are any technical errors or poor quality. Please see the attachment.

2. Quality Assurance- Review of a sample of IP interpretation by other Interpreting MD reviewers:
   a. To assess whether the IP accepted images which meet the image quality standards of the American Board of Radiology (ABR), our mammography facility has arranged a mechanism to audit IP peer reviews by other IPs in order to ensure of reliability, clarity, and accuracy of the interpretation of mammograms by each IP.
   b. Women's Diagnostic Center's lead interpreting physician (LIP) randomly selects sample image dictated reports from other IPs who read mammograms in our facility. LIP will fill out a designated Peer IP Reviewers' form by reflecting patient's MRN and the Date that the mammogram has been performed and dictated. LIP will send the forms to other radiologists who read mammograms in our Women's Diagnostic Center in order to audit and review sample images and dictate reports from other IPs. IP reviewers will review and completing the form by marking as Concordant interpretation or Discordant Interpretation. Review results will be discussed with IP reviewer and IP performer; the form will be signed and dated by Primary interpreting MD performer and interpreting MD reviewer.
   c. Women's Center supervisor will collect all forms in a designated EQUIO folder and all data will be reviewed quarterly by LIP. Please see the attachment.
3. Quality Control- Facility QC Review
   a. To comply with MQSA, EQUIP standards, our mammography facility has stablished a procedure to assure facility's LIP is responsible for providing oversight of the QA/QC records, including a review of the frequency of performance of all required tests, and review of any corrective action. LIP will review and sign facility's QC charts for all of the mammography exam rooms as well as printer and radiologists' reading monitors. Quarterly, facility's supervisor and QC technologist presenting daily/monthly/quarterly/semi-annually/annually QC file to LIP for review. LIP correlates information with QC charts to assure that QC tests whether or not are comply with MQSA standards within accurate range. LIP signs and dates on the approved QC review sheet along with QC technologist's and Supervisor's signature. Please see the attached form.
   b. Facilities will be cited for violations if they have not complied with MQSA/EQUIP standards. Facility's state inspector will review all the above requirement during annual MQSA inspections.

C. **RELATED DOCUMENT(S):**
1. **Clinical Image Quality Assurance Program Regular Review of a Sample of Images**
2. **Daily Operation of Quality Assurance – Clinical Image Corrective Action by IPs to RTs in Women's Diagnostic Center**
3. **Equip Facility QC Review Quarterly**
4. **Facility QC Review**
~~1.~~5. **Quality Assurance Review by Interpreting Physician**

~~B.~~A. **REFERENCE(S):**
1. MQSA Clinical Image Quality-Related Regulations:
2. http://www.fda.gov/Radiation-EmittingProducts/mammoraphyQualityStandardActandprocedures
3. EQUIP: Enhancing Quality Using the Inspection Program
4. U.S Department of Health and Human Services
5. Food and Drug Administration (FDA)

Clinical Image Quality Assurance Program
Regular Review of a Sample of Images
From _____ to _____

Technologist	MRN	Date of Exam	Optical Image Quality Y or N	Corrective Action Taken

Interpreting Physician _____

Physician Signature _____ Date _____

Daily Operation of Quality Assurance- Clinical Image Corrective Action by IPs to RTs in Women's Diagnostic Center

To continue providing quality assurance and to promote clinical image quality, our Women's Diagnostic Center has implemented a mechanism for providing ongoing IP feedbacks on image quality to RTs on a daily basis. This mechanism provides documentations of any corrective action on any poor image quality by the IP reviewer.

Accreditation bodies standards for image quality attributes to:

1. **Positioning ( )**
2. **Motion due to improper compression, or other causes ( )**
3. **Compression ( )**
4. **Exposure Level ( )**
5. **Contrast ( )**
6. **Sharpness ( )**
7. **Noise ( )**
8. **Artifacts ( )**
9. **Image Identification ( )**

IP Reviewer's Comments _____

_____

Corrective Action:

( ) Technical Repeat; Patient needs to be called back to repeat the positioning

( ) Please review the images with technologist; patient does not need to be called back but technologist need to review the images and documentatons

Interpreting Physician _____ **Date:** _____

( ) Case reviewed and discussed with technologist.

Supervisor: _____ **Date:** _____

EQUIP FACILITY QC REVIEW
QUARTERLY

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2017												
2018												
2019												

Facility QC Review

Facility MAP ID _____ Date of QC _____

1. Review Medical physicist Surveys and Results Reviewed_____

	Room1	Room 2	Room 3	Stereo R
MAP ID				
DATE OF LAST SURVEY				
CORRECTIVE ACTION COMPLETED				
PHANTOM AVEG DOSE				
FIBER SCORE				
SPECK SCORE				
MASS SCORE				

2. Review Tech QC

Test Frequency Summary Comments from Last Quarter

Reviewed _____

ACR Phantom Image Quality Weekly _____

	Room1	Room2	Room3	Stereo R
MAP ID				
DATE				
Fiber Score				
Speck group Score				
Mass Score				

Reviewed _____

Facility QC Review (Continued)

QC Module	Room 1	Room 2	Room 3	Stereo Room
MAP ID Number				
Visual Checklist				
Repeat Analysis				
Compression				
Image Plate Fog				
Review Workstation				
Phantom Control				
Artifact Evaluation				
QC Tech Data Collection				
Printer Checklist				

3. Notable Findings during QC meeting, items for QC improvement, and other QC notes:

Lead Interpreter Radiologist
Date:_____

Facility Manager

QC Technologist

Interpreting Physicians' Peer Reviews by Other IP

Interpreting Physician Peer Reviewer: _____

Exam Identification (MRN): _____

Date of the Exam Performed: _____

Interpreting Physician Performer: _____

Image Quality Standards	Positioning	Exposure Levels	Contrast	Sharpness	Noise	Artifacts	Examination Identifications
Meet Quality Standards of Accreditation Bodies							
Medical Outcomes Ensures of Reliability, Clarity, and Accuracy of the Interpretation							
IP Peer Reviewer's Comments							

Clinical Images continue to comply with the clinical image quality standards established by Tri City Women's Diagnostic accreditation body:

Quality of clinical Images need to improve to comply with Accreditation body (AB) of radiologic technology standards:

IP Peer Reviewer: _____

IP Peer Reviewer Signature: _____ Date: _____

Quality Assurance Review by Interpreting Physician

Tri-City Medical Center
Women's Diagnostic Center
4002 Vista Way
Oceanside, CA 92056
(760) 940-7470

MRN _____ DATE: _____ INTERPRETING MD: _____
TECHNOLOGIST: _____

REVIEW COMMENTS:

ATTRIBUTE	PROBLEM(S) NOTED	PROBABLE CAUSE(S)
A. Positioning	( )Poor visualization of posterior tissues ( )Sagging breast ( ) Inadequate amount of pectoral muscle shown on image ( ) Inadequate inframammary fold (IMF) ( ) Excessive exaggeration ( ) Portion of breast cut off ( ) Skin folds ( ) Other body parts projected over breast ( ) Breast positioned too high on image receptor ( ) Posterior nipple line (PNL) on CC not within 1 cm of ML PNL	( ) Technologist technique ( ) Inappropriate mammographic projections ( ) Wrong size image receptor ( ) Uncertain ( ) Other:
B. Compression	( ) Poor separation of parenchymal densities ( ) Non-uniform exposure levels ( ) Patient motion ( ) Other	( ) Under compression by technologist ( ) Unsuitable compression device ( ) Technologist positioning of compression device ( ) Uncertain ( ) Other:
C. Exposure Level	( ) Generalized underexposure ( ) Generalized overexposure ( ) Inadequate penetration of dense areas ( ) Excessive penetration of lucent areas ( ) Other	( ) Under compression with phototiming ( ) Radiologist preference ( ) Phototimer variability ( ) Uncertain ( ) Other:
D. Contrast	( ) Inadequate contrast ( ) Excessive contrast ( ) Other	( ) Underexposure ( ) Digital: window width too wide ( ) Digital: window width too narrow ( ) Improper kVp ( ) Uncertain ( ) Other:
E. Sharpness	( ) Poor delineation of linear structures ( ) Poor delineation of feature margins ( ) Poor delineation of microcalcifications	( ) Patient motion ( ) Uncertain ( ) Other:

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Women's Diagnostic Center
4002 Vista Way
Oceanside, CA 92056
(760) 940-7470

CLINICAL IMAGE CORRECTIVE ACTION
Page 2

F. Noise	( ) Visually striking mottle pattern ( ) Noise limited visualization of detail	( ) Digital: inadequate SNR ( ) Digital: window width too narrow ( ) Improper kVp ( ) Uncertain ( ) Other:
G. Artifacts	( ) Hair, deodorant, etc. ( ) Poor screen-film alignment ( ) Digital: image receptor artifact ( ) Digital: laser printer artifact ( ) Digital: Laser printer "scanning" ines ( ) Other	( ) Lack of patient preparation ( ) Digital: detector calibration (e.g. uniformi calibration) ( ) Digital: foreign objects calibrated into calibtaion file ( ) Digital: laser printer needs service ( ) Uncertain ( ) Other:
H. Exam ID	( ) Explain:	( ) Explain
Additional Recommendations		
Additional Comments		

CORRECTIVE ACTION: ☐ TECHNICAL REPEAT: Patient recalled for additional, corrective imaging

Date: _____ Technologist: _____

☐ CASE REVIEWED BY INTEPRETING PHYSICIAN WITH TECHNOLOGIST

Date: _____ Technologist: _____

Interpreting Physician: _____ Manager: _____

Tri-City Medical Center
Oceanside, California

DELETE – no longer required

Mammography Women's Center
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 05/99

SUBJECT: Health Physicist Testing

REVISION DATE(S):

~~POLICY NUMBER:~~
~~CROSS REFERENCE:~~

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/11

~~A. AUTHORIZED TO PERFORM:~~
~~1. Health physicist.~~

~~B. PURPOSE:~~
~~1. To assure proper functioning of mammography machines.~~

~~C. POLICY:~~
~~1. We currently contract with the company below to carry out these services:~~
~~Quality Assurance Services, LLC~~
~~1500 Via Hacienda~~
~~Chula Vista, CA 91913~~
~~Dr. Donald Holmes, or Glen Deacon, MSEE (619)482-1003~~

~~D. PROCEDURE~~

~~*Test*~~	~~*Frequency*~~	~~*Test*~~
~~Estimated skin entrance Exposure~~	~~Annually~~	~~Calculated from exposure measurements~~
~~Glandular tissue dose~~	~~Annually~~	~~TLD or ion chamber~~
~~Exposure timer accuracy~~	~~Annually~~	~~Digital timer~~
~~Phototimer reproducibility~~	~~Annually~~	~~Phantom and ion chamber~~
~~kVp accuracy~~	~~Annually~~	~~kVp meter or cassettes~~
~~mAs linearity reproducibility~~	~~Annually~~	~~Ion chamber or digital timer~~
~~Half value layer (HVL)~~	~~Annually~~	~~Aluminum HVL set with ion chamber~~
~~Focal spot size~~	~~Annually~~	~~Star pattern test tool~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: **SUBJECT: Implants**

REVISION DATE(S): ~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE:**~~

Department Approval:	**10/17**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Radiologic Technologist possessing certification from the **American Registry of Radiology Technologists** (A~~.~~R~~.~~R~~.~~T~~.~~) and California **Certified Radiologic Technologist** (C~~.~~R~~.~~T~~.~~) in Mammography. Must have performed 200 mammograms in a 24-month period as per **Mammography Quality Standard Act** (M~~.~~Q~~.~~S~~.~~A) regulations.

B. **PURPOSE:**
1. To provide consistent guidelines for ~~l~~imaging patients with implants.

C. **POLICY:**
1. Implant Mammography is categorized as a Diagnostic Mammogram in accordance with **American College of Radiology** (A~~.~~C~~.~~R~~.~~) guidelines. Implant displacement views to be done in addition to implant views on all patients with implants unless encapsulated.

D. **PROCEDURE:**
1. Consent signed by the patient.
2. Views to be done are:
   a. Craniocaudal views with displacement views (cc).
   b. Mediolateral Oblique views with displacement views (mlo).
3. If breast is encapsulated and unable to do displacement views, do the following views:
   a. Craniocaudal views (cc)
   b. Mediolateral Oblique views (mlo)
   c. Mediolateral views (ml)

E. **EXTERNAL LINK(S):**
1. **Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf**

F. **REFERENCE(S):**
~~c.~~**1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).**

Tri-City Medical Center
Oceanside, California

DELETE – follow Infection Control policies Cleaning, Disinfecting and Sterilization and Standard and Transmission Based Precautions

Mammography Women's Center
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 11/99

SUBJECT: Infection Control

REVISION DATE(S):

~~**POLICY NUMBER:**~~
~~**CROSS-REFERENCE:**~~

Department Approval Date(s):	**10/17**
Department of Radiology Approval Date(s):	**06/18**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Professional Affairs Committee Approval Date(s):	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval Date(s):	**08/11**

~~A. **AUTHORIZED TO PERFORM :**~~
~~1. Mammography Technologists.~~

~~B. **PURPOSE:**~~
~~1. To prevent and control the spread of infection to employees, patients, and visitors within the mammography facility.~~

~~C. **POLICY:**~~
~~1. Employees will adhere to TCMC universal precautions and standards of Infection Control Policies per TCMC Infection Control Manual. The Infection Control policies comply with all applicable federal, state and local regulations, manufacturers' recommended procedures and generally accepted guidance on infection control. Specific guidelines for mammography include the following to be performed between each patient.~~
~~a. Mammography rooms are to be straightened between patients.~~
~~b. All surfaces in contact with patients are to be wiped clean with approved disinfectant while following instructions according to the manufacturers specification at the end of each examination.~~
~~c. All staff should wash their hands between contacts with different patients.~~
~~d. All linens are for single use. Following use, they are to be deposited in dirty laundry container.~~
~~e. Any spills or drips on floors or equipment must be washed with approved disinfectant and with proper personal protective equipment.~~
~~f. Blood or bodily fluids follow TCMC policy and have disinfectant log posted in each room.~~
~~g. PDI – Sani-Cloth germicidal disposable wipes are the approved hospital and equipment manufacturers disinfecting solution utilized for all cleaning of mammography equipment.~~

Tri-City Medical Center
Oceanside, California

DELETE – no longer required

Mammography Women's Center
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 09/97

SUBJECT: Master Jacket Retrieval & Filing

REVISION DATE(S):

~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE:**~~

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/11

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

~~1. To establish guidelines for proper radiology medical record preparation.~~

~~B. **POLICY:**~~

~~1. The employee must gather all required paperwork and films from previous exams to present to radiologist for interpretation of the current exam.~~

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

~~1. If patient has not been to Imaging Services before, follow P&P, "Making a new Master Jacket"~~
~~2. If patient has had previous visits to Imaging Services, check RIS for dates and location of all old master jackets.~~
~~a. When appropriate refer to card file for OPIC.~~
~~3. Prepare "Pull List" for retention from other storage location.~~
~~4. Assigned personnel will pull all requested files and return to requestor.~~
~~5. Follow P&P "Combing OPIC & TCMC jackets".~~
~~6. Update any appropriate information on jacket.~~
~~7. Submit to radiologist for interpretation (if not already completed).~~
~~8. After exam has been dictated, collate films and assure all are present, and hold for typed report.~~
~~9. When diagnostic report has been typed, file in report jacket in reverse chronological order and file in Master Jacket.~~
~~10. Return Master Jacket to appropriate file location.~~
~~a. File by year of last exam.~~
~~b. Filing is done in terminal digit order. Filing follows as below. Patient's Medical Record Number Is: 01234567~~

~~0~~	~~2~~	~~4~~	~~6~~
~~1~~	~~3~~	~~5~~	~~7~~
~~D~~	~~D~~	~~D~~	~~D~~
~~4th~~	~~D~~	~~D~~	~~D~~
	~~3rd~~	~~D~~	~~D~~
		~~2nd~~	~~D~~
			~~1st level~~

Tri-City Medical Center
Oceanside, California

DELETE – follow Administrative Policies: New Hire Orientation 547 and Competency 458

Mammography Women's Center
~~Diagnostics, Imaging & Therapeutics Policies & Procedures~~

ISSUE DATE: 11/99

SUBJECT: Personnel Orientation for OPIC Center

REVISION DATE(S):

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/11

~~A. PURPOSE:~~

~~1. To ensure consistency and competency of staff in performance of assigned tasks.~~

~~B. POLICY:~~

~~1. All employees will have orientation related to scope of work, according to regulatory standards and hospital policy. Technologists will complete orientation program and competency checklists within 90 days of hire.~~

~~C. PROCEDURE:~~

~~1. Continuing education requirements and annual competencies, including radiation safety will be completed and documented as part of the evaluation process.~~

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into QC Policy with duplicate information

Mammography
~~Women's Diagnostic Center Policies & Procedures~~

ISSUE DATE: 08/07 **SUBJECT:** QC Policy Phantom

REVISION DATE(S):

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/07

~~A. AUTHORIZED TO PERFORM:~~
~~1. Licensed Mammography technologists who have received training and education and achieved competency in Quality Control procedures.~~

~~B. PURPOSE:~~
~~1. To ensure quality results by consistent performance and documentation of Q.C. procedures and adherence to MQSA equipment standards.~~

~~C. POLICY~~
~~1. TCMC Women 's Diagnostic Center will provide compliance with State and Federal Standards. Staff scheduled to perform all daily/weekly QC. On equipment. Any QC problem will be immediately addressed with Supervisor. Bi-Annual meeting between leadership, lead interpreting Radiologist and staff will be held to review and sustain a quality program.~~

~~D. PROCEDURE~~
~~1. Weekly Phantom:~~
~~a. Phantom exposed per Fuji manufacturer's guidelines.~~
~~b. Results posted in Q.C. manual. To be performed by Techs assigned to the room or the Q.C. technologist~~
~~2. Weekly CNR~~
~~a. To confirm that contrast to noise ratio remains consistant over time at same exposure settings.~~
~~3. Weekly laser printer~~
~~a. To be performed at beginning of work week prior to processing any clinical images. Document in Q.C. manual.~~
~~4. Daily secondary Erasure:~~
~~a. All imaging plates to be secondary erased prior to beginning patient mammography.~~
~~5. Daily monitor Sempte;~~
~~a. To ensure that the interpretation monitors are clear and calibrated prior to reading images.~~

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~Women's Diagnostic Center Policies & Procedures~~

ISSUE DATE: 08/07 **SUBJECT: Quality Control (QC) Policy**

REVISION DATE(S):

Department Approval:	**10/17**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography technologists who are scheduled in mammographic room and have demonstrated competency **in Quality Control (QC) procedures**.

B. **PURPOSE:**
1. To ensure compliance by ~~consistant~~**consistent** performance and documentation of Q~~.~~C~~.~~ procedures and adherence to **Mammography Quality Standard Act** (MQSA) and manufacturers guidelines.

C. **POLICY:**
1. TCMC will provide Q~~.~~C~~.~~ in compliance with state and federal standards. Q~~.~~C~~.~~ tech or, in ~~her~~ **their** ~~absense~~**absence**, licensed mammography tech who is competent in QC will be responsible for all daily/weekly Q~~.~~C~~.~~ on equipment. Any Q~~.~~C~~.~~ problem will be immediately addressed with supervisor and Operations Manager. Semi-annual meetings between the Mammography supervisor, Lead Interpretating Radiologist and Imaging Director will review and sustain quality program.

D. **PROCEDURE:**
1. Daily Secondary Eraser·:
   a. To ensure that imaging plates are clean, clear and ready for exposure. Once completed, place the "completion" signage on cassettes.
2. **Daily monitor SEMPTE:**
   a. **To ensure that the interpretation monitors are clear and calibrated prior to reading images.**
~~2.~~**3.** Weekly Phantom:
   a. Phantom exposed per manufacturers (Fuji) guide- lines, results posted in Q~~.~~C~~.~~ manual.
~~3.~~**4.** Weekly **Contrast to Noise Ratio** (CNR):
   a. To confirm that **CNR**~~Contrast to Noise Ratio~~ remains ~~consistant~~**consistent** over time at the same exposure settings. Document in QC manual.
~~4.~~**5.** Weekly Printer Dry Pix 4000
   a. Perform at beginning of workweek prior to processing any clinical images. Document in Q~~.~~C~~.~~ manual

E. **EXTERNAL LINK(S):**
1. **The Mammography Quality Standards Act Final Regulations: Preparing for MQSA Inspections; Final Guidance for Industry and FDA**

(2001) https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm094441.pdf

F. REFERENCE(S):

~~a.~~1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 11/99 | **SUBJECT: Report Inclusions**

REVISION DATE(S): | ~~**POLICY NUMBER:**~~ ~~**CROSS REFERENCE:**~~

Department Approval:	**10/17**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. **Physicians**~~**M.D.'s**~~ and Radiology Transcriptionists.

B. **PURPOSE:**
1. To ensure all required information is included in dictated patient's reports.

C. **POLICY:**
1. Mammography reports shall include all essential elements per **Mammography Quality Standard Act** (MQSA) standards:
   a. Name and **medical record number** (MRN) of patient
   b. Date of exam
   c. Name of interpreting physician
   d. Final assessment in one of the named categories:
      i. Negative
      ii. Benign
      iii. Probably benign
      iv. Suspicious
      v. Highly suggestive of malignancy
2. NOTE:
   a. If no final category is assigned due to incomplete work-up:
      i. Incomplete: "Need further work-up" shall be assigned.

D. **EXTERNAL LINK(S):**
1. **Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf**

E. **REFERENCE(S):**
~~i.~~1. **Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 05/99	**SUBJECT:** RejectRetake/Repeat Analysis
REVISION DATE(S):	**~~POLICY NUMBER:~~**
	~~CROSS REFERENCE:~~

Department Approval:	**10/17**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography Technologist.

B. **PURPOSE:**
1. To determine the number and cause of repeated mammograms and rejected films.

C. **POLICY:**
1. To be done monthly.

D. **PROCEDURE:**
1. Each technologist will enter any repeat film done and why repeated in the **diagnostic radiology (~~IDX rad~~) EMR** computer system when completing the exam.
2. Monthly, the supervisor will pull statistics from the ~~IDX rad computer~~ **EMR** system and review the repeat rate percentage.
3. If the repeat or reject rate changes from the previously determined rate (3.0% or less) by more than 2.0%, the reason for the change shall be determined. Any additional teaching or education of technologists will be done. Any corrective actions will be documented by supervisor and placed in repeat analysis statistics binder.

E. **REFERENCE(S):**
~~4.~~1. **U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm**

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER
~~PATIENT CARE SERVICES POLICY MANUAL~~
~~Women's Diagnostic Center~~

ISSUE DATE: 11/99

REVISION DATE(S):

SUBJECT: Standardized Labeling of Mammograms

~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE:**~~

Department Approval:	**10/17**
Department of Radiology Approval:	**06/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**08/11**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography Technologist

B. **PURPOSE:**
1. To ensure that films are not lost or misinterpreted.

C. **POLICY:**
1. Each mammographic image shall have permanent and complete, legible information appropriately placed so as not to obscure anatomic structures.
   a. Name of patient, DOB, and MRN number.
   b. Date of exam.
   c. View and laterality. This information should be placed on the image near the axilla.
   d. Facility name and location.
   e. Technologist identification (initials).
   f. Cassette/screen identification.
   g. Mammography unit identification.

Tri-City Medical Center
Oceanside, California

Mammography Women's Center
~~PATIENT CARE SERVICES POLICY MA~~
~~Women's Diagnostic Center~~

DELETE – follow Administrative Policies: New Hire Orientation – 457, Monitoring Licenses, Professional Registrations and Certificates - 430 and Competency - 458

ISSUE DATE: 08/94

SUBJECT: Training/Orientation/Competency and Continuing Education

REVISION DATE(S): 10/97
REVIEW DATE(S): 10/97, 01/99

~~**POLICY NUMBER:**~~
~~**CROSS REFERENCE:**~~

Department Approval Date(s):	10/17
Department of Radiology Approval Date(s):	06/18
Pharmacy and Therapeutics Approval Date(s):	n/a
Medical Executive Committee Approval Date(s):	n/a
Professional Affairs Committee Approval Date(s):	n/a
Administration Approval:	08/18
Board of Directors Approval Date(s):	08/11

~~A. **RESPONSIBILITY:**~~
~~1. Department director, Coordinators, Leads~~

~~B. **PURPOSE:**~~
~~1. To ensure adequate training, orientation for job performance of the new employee. To ensure initial competency, continued competency and continuing education relating to job functions.~~

~~C. **POLICY:**~~
~~1. The Diagnostics, Imaging & Therapeutics Departments (DIT) will provide an orientation program of sufficient scope and duration to inform the new employee of his/her responsibilities and how to fulfill them. Orientation will include a hospital orientation day and a department specific orientation with special emphasis on job tasks, duties and responsibilities related to the job description. This process will be documented (in personnel files) and supervised by the coordinator of the area or designated preceptors.~~
~~2. Licenses are verified and competency will be assessed upon initial hire, during orientation and periodically thereafter. Each area will define specific ongoing competencies (and continuing education) based upon (but not limited to) annual evaluations, quality review reports, high risk, invasive or problem prone performance, staff or physician input, new services or equipment, process improvements and age specific competencies.~~
~~3. In addition to specifically designated competencies, all employees complete an annual safety and infection control competency review and test. Documentation of all competencies is maintained in the employee's personnel file and is part of the annual evaluation process.~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF POLICY~~MANUAL~~

DELETE: No longer have Laser and Aesthetics Center.

ISSUE DATE: 08/11

SUBJECT: Credentialing Criteria, Laser and Aesthetic Center

REVISION DATE(S):

POLICY NUMBER: 8710 – 565

Department Approval:	07/17
~~Subspecialty Division Approval:~~	~~02/13~~
~~Dermatology Division Approval:~~	~~02/13~~
~~Family Medicine Department Approval:~~	~~02/13~~
Interdisciplinary Practice Committee Approval:	~~03/13~~10/17
Credentials Committee Approval:	~~03/13~~01/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/13~~07/18
Professional Affairs Committee Approval:	n/a
Administration Approval:	08/18
Board of Directors Approval:	03/13

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

~~To provide criteria for use in credentialing physicians and Allied Health Professionals who request privileges in laser and aesthetic procedures at the Laser and Aesthetic Center located at 6250 El Camino Real, Carlsbad.~~

~~B. **INITIAL CREDENTIALING:**~~

~~1. For physicians:~~

~~a. Board Certified by the American Board of Dermatology or the American Board of Plastic Surgery (or the equivalent osteopathic board) or have completed an ACGME approved residency in dermatology, plastic surgery or facial plastic surgery; OR~~

~~b. Board Certified by the American Board of Family Medicine or the American Board of Internal Medicine or the American Board of Otolaryngology (or the equivalent osteopathic board) or have completed an ACGME approved residency in family medicine, internal medicine or otolaryngology AND provide documentation of successful completion of an accredited aesthetics & laser training course consisting of at least fifteen (15) credit hours, including hands on experience; AND~~

~~c. Documentation of completion of Cutera laser training (if laser privileges are requested); AND~~

~~d. Documentation of professional liability insurance coverage for aesthetic/laser procedures.~~

~~2. For Physician Assistants:~~

~~a. Meets the qualifications for Allied Health Professional status as set forth in the Allied Health Rules and Regulations;~~

~~b. Certified by the National Commission on Certification of Physician Assistants;~~

~~c. Delegation of Services Agreement and Supervising Physician's Responsibility for Supervision of Physician Assistant;~~

~~d. Documentation of completion of Cutera laser training (if laser privileges are requested);~~

~~e. Documentation of successful completion of an accredited aesthetics and laser training course consisting of at least fifteen (15) credit hours, including hands on experience;~~

~~f. Documentation of professional liability insurance coverage for aesthetic/laser procedures.~~

C. PROCTORING AND REAPPOINTMENT REQUIREMENTS

PROCEDURE	PROCTORING	REAPPOINTMENT
• Hair removal with Pro-Wave 770 laser • Hair removal with Nd: YAG laser	3 cases	3 cases
• Skin tightening with Titan laser • Treatment of vascular skin lesions with Nd: YAG laser • Skin rejuvenation with Nd: YAG Laser Genesis	4 cases	4 cases
• Skin resurfacing with Pearl Fractional laser (NOTE: Physician Assistants are not eligible for this procedure) • Intense pulse light skin treatment with Limelight laser	4 cases	4 cases
Dermal Filler Procedures, injection of any of the following: Juvederm Ultra, Juvederm Ultra Plus, Restylane, Sculptra, Radiesse	2 cases	2 cases
Botulinum Toxin A Procedures, injection of any of the following: Dysport, Botox	2 cases	2 cases

D. ONGOING PROFESSIONAL PRACTICE EVALUATION

1. Cases will be reviewed on an ongoing basis and reported to the Division of Subspecialty Surgery with the goal of patient safety and successful performance of the procedure(s).

Approvals:

Subspecialty Division Approval: 02/13
Dermatology Division Approval: 02/13
Family Medicine Department Approval: 02/13
Interdisciplinary Practice Committee Approval: 03/13
Credentials Committee Approval: 03/13
Medical Executive Committee Approval: 03/13
Board of Directors Approval: 03/13

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 03/06	**SUBJECT:** Cultural and Linguistic Proficiency
REVISION DATE: 05/08; 08/12; 09/14~~07/12; 07/14~~	**POLICY NUMBER:** 8710-601

Department Approval:	07/18
Continuing Medical Education Committee Approval:	04/08; 07/12; 08/14: 07/18
Medical Executive Committee Approval:	05/08; 08/12; 09/14; 08/18
Professional Affairs Committee:	n/a
Administration Approval:	08/18
Board of Directors Approval:	05/08; 08/12; 09/14

A. **PURPOSE:**
To ensure subjects of cultural and linguistic competency in the practice of medicine are included in Continuing Medical Education (CME) activities in accordance with California Bill AB 1195. The IMQ/CMA policy applies to non-exempt CME activities and addresses the essential elements for compliance with Assembly Bill 1195 and was updated by the Boards of CMA and IMQ in July and August 2013.

B. **DEFINITIONS:**
1. **Cultural Competency:** A set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities.
2. **Linguistic Competency:** The ability of a physician and surgeon to provide patients who do not speak English, or who have limited ability to speak English, with direct communication in the patient's primary language.

C. **POLICY:**
1. **Identification of CLC Disparity:** Planners are responsible for proactively identifying one (or more) CLC disparities when planning an educational activity with **clinical content**. The CLC disparity must be relevant to the identified gaps or learning needs of the target audience or our patient population.
   a. Faculty is not responsible for identifying CLC disparities.
   b. The planner will document on the planning form if there is no clinical care component or no CLC disparity identified.
2. **Objectives:** Tri-City Medical Center shall include cultural and linguistic objectives in CME activities that address cultural beliefs, which may include cause, severity, treatment, and acceptability of the patient's own illness, as well as, language barrier implications and the need for providing appropriate interpreters and appropriately interpreted material. Objectives shall include at least one, or a combination of, the following:
   a. Application of linguistic skills to communicate effectively with the target population.
   b. Utilization of cultural information to establish therapeutic relationships.
   c. Elicitation and incorporation of pertinent cultural data in diagnosis and treatment.
   d. Understanding and application of cultural and ethnic data to the process of clinical care.
3. **Cultural Diversity Form:** Each CME speaker shall complete and sign a *Cultural Diversity* form which informs the speaker of the requirement that cultural and linguistic information/resources are required for each CME activity with clinical content.
4. Cultural references shall be made available to attendees at CME activities.

D. FORM(S):

1. Cultural Diversity Form - Sample

E. RELATED DOCUMENT(S):

~~4.~~1. Tri-City Medical Center "A Guideline for General Cultural Awareness" – Sample

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

*Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014 CME Accreditation Criteria and Policies for Continuing Medical Education (CME) *with annual report glossary.*

~~**E. APPENDIX:**~~

~~1. Cultural Diversity Form~~
~~2. Tri-City Medical Center "A Guideline for General Cultural Awareness"~~

Cultural Diversity Form - Sample

Tri-City Medical Center
CULTURAL DIVERSITY FORM

Date: _____

Topic: _____

Speaker: _____

The California legislature passed AB 1195, which states that as of July 1, 2006 all Category 1 CME activities that relate to patient care must include a cultural diversity/linguistics component.

DEFINITIONS: Cultural competency means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. Linguistic competency means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

We believe there is relevant cultural diversity information relating to one or more of the following: age, gender, race, socio-economics, sexual orientation, religion, language, ethnicity, etcetera that impacts the care of patients and you are required to include it in your presentation. If no relevant cultural or linguistic health or health care disparities are identified, this should be documented.

Therefore, the following objective will be added to the activity publicity to potential attendees and also to the attendee evaluation form:

Discuss the various culturally relevant diversities (gender, age, race, religion, ethnicity, language, sexual orientation, socio-economics, etc.) that relate to demographics, diagnosis, and treatment.

I have read this form and will comply with AB 1195 as outlined above.

Signature:_____ Date:_____

Cultural Awareness Guide - Sample

Tri-City Medical Center

A Guideline for General Cultural Awareness

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
American English	Christian and Jewish beliefs are prominent. Many others exist in smaller numbers. Family-oriented.	Beef, chicken, potatoes, vegetables; fast foods; ethnic foods.	Talkative, shake hands, not much touching during conversation. Prefer to gather information for decision-making. Some hugging and kissing, mainly between women.	Family members and friends visit in small groups. Expect high-quality care.
Argentinean Spanish	90% Catholic, some Protestant and Jewish. Strong belief in saints, purgatory, and heaven. People from rural areas may be more superstitious.	Emphasis on meat, especially beef with homemade pastas, pastries, and local wines. Maté, national beverage that is stimulating and "addictive" like coffee.	Talkative, very expressive, direct and to the point. Extroverted. Good eye contact. Like personal and physical contact such as holding hands, hugging, and kissing.	Educated, yet reluctant to get medical attention or accept new medical advancements. Independent, often deny disability. Believe in natural and holistic remedies, herbal teas, pure aloe, natural oils, and poultices. Family gets involved with caring for the ill family member.
Brazilian Portuguese. Diverse cultural backgrounds including: European, African, Indian.	Mostly Catholic. Growing Evangelical representation. Candomble, similar to Santeria. Macumba (blend of African, Brazilian, Indian).	Beans and rice are staple. Feijoada-black beans, beef, and pork; churrasco (charcoal-broiled meats); manioc (vegetable); tropical fruits.	Very sociable. Will stand close to each other. Social kissing, hugging, touching, good eye contact.	Emphasis on family unity – will want to be actively involved. Tend to trust medical personnel; place great faith in doctors and nurses. Some believe in herb treatment, teas, and balsams.
Canadian English, French and Innuit (Eskimo)	Protestant, Catholic, and Jewish. 80% of the population lives within 1,00 miles of the United States boarder.	Comparable to American diet. French influence in Montreal and Quebec.	Prefer no touching or kissing. Take things at face value.	Follow nurses' instructions. Accustomed to socialized medicine, less litigation. Take physicians at their word. Willing to wait for treatment.
Cayman English, with some changes in accents and verbs.	People are very religious. Majority of the island is Baptist or "Church of God." Voodoo and psychics are outlawed.	Fish, turtle, beef, goat, and conch; rice, beans, and plantains; fried food very rich in fat; cooked or fried in coconut oil or milk.	Like to be acknowledged. Good eye contact. Prefer no touching or kissing. Very talkative and known for their friendliness. Everyone on the island knows each other.	Like to be told what is going on by doctor. Would rather talk to doctors than nurses. Prefer one-on-one care.
Chinese Many dialects spoken; one written language.	Religions: Taoism, Buddhism, Islam, and Christianity. Harmonious relationship with nature and others; loyalty to family, friends, and government. Public debate of conflicting views is unacceptable. Accommodating, not confrontational. Modesty, self-control, self-reliance, and self-restraint. Hierarchical structure for interpersonal and family interactions.	Belief in theory of "yin" (cold) and "yang" (hot) when they are sick. No food with "yin" after surgery (e.g., cold desserts, salad). Often lactose intolerant. Soy sauce, MSG, and preserved foods. Diet consisting of vegetables and rice. Tofu (bean curd) can be prepared in various ways.	Quiet, polite, and unassertive. Suppress feelings of anxiety, fear, depression, and pain. Eye contact and touching sometimes seen as offensive or impolite. Emphasize loyalty and tradition. Self-expression and individualism are discouraged.	Women uncomfortable with exams by male physicians. May not adhere to fixed schedule. May fear medical institutions. Use a combination of herbal and Western medicine at the same time. Traditional: acupuncture, herbal medicine, massage, skin scraping, and cupping. Alcohol may cause flushing.
Cuban Spanish	Catholic with Protestant minority. Santeria, which can include animal sacrifice.	Cuban bread, café con leche, Cuban coffee; roast pork, black beans, and rice; plantains, yucca, chicken and rice.	Some may have a tendency to be loud when having a discussion. Use their hands for emphasis and credibility, and prefer strong eye contact.	Culture requires visiting the sick; the extended family supports the immediate family. It is an insult to the patient if there is not a large family/friend presence.
Ecuadorian Spanish, Quechua-Indian	Primarily Catholic. Increase in Protestant, Baptist, and Jehovah Witness. Very respectful toward religious leaders. Small percentage of population is wealthy with much political control. Family size is usually large.	Diet high in fruits and proteins; starches: rice, potatoes, and corn. Food is prepared fresh daily, usually with salsa. Coastal diet: rice and fish (ceviche). Drink beer and soda.	Extremely polite. Reserved. Respectful. Especially helpful.	Prefer pampering ill family members; stay overnight with patient. Not stoic when it comes to pain. Very private and modest. Embarrassed if they do not look their best. Extremely protective of family; often parents live with grown children.
Filipino English, Spanish, and Tagalog (80 Dialects)	Catholic. Seek both faith healer and Western physician when ill. Belief that many diseases are the will of God.	Theory of hot and cold food. Certain foods in the Philippines are traditionally eaten hot or cold, e.g. milk is only taken HOT. Fish, rice, vegetables, and fruit. Meals have to be HOT.	Value and respect elders. Loving and family-oriented. Set aside time just for family.	Family decision important. Ignore health-related issues; often noncompliant. In spite of Western medicine, they often leave things in the hands of God, with occasional folk medicine. Home remedies: herbal tea, massage, and sleep. May subscribe to supernatural cause of disease.

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
Guatemalan Spanish; Mayan heritage; European influence	Primarily Catholic. Increase in Protestants. Very respectful toward elders. European heritage; strong family ties.	Diet high in fruits, vegetables, rice, beans, and tortillas (corn flour bread).	Quiet, reserved, and respectful. Will not question for fear of insulting professional.	Modest, private, and stoic. Believe in alternative methods of healing.
Haitian Creole; French is taught in schools	Catholic and Protestant. Voodoo is practiced. Large social gap exists between wealthy and poor citizens.	Large breakfast and lunch. Light dinner. Rice, fried pork, grillot, and red beans. Herbs and cloves.	Quite and polite. Value touch and eye contact.	Obedient to doctor and nurse, but hesitant to ask questions. View use of oxygen as indication of severe illness. Occasionally share prescriptions and home remedies.
Hindu Hindi	The belief in cyclic birth and reincarnation lies at the center of Hinduism. The status, condition, and caste of each life is determined by behavior in the last life.	Cow is sacred. No beef. Some strictly vegetarian.	Limited eye contact. Do not touch while talking.	Do not try to force food when religiously forbidden. Death: The priest may tie a thread around the neck or wrist to signify a blessing. This thread should not be removed. The priest will pour water into the mouth of the body. Family will request to wash the body. Eldest son is responsible for the funeral rites.
Jamaican English, Patois (broken English)	Christian beliefs dominate (Catholic, Baptist, and Anglican). Some Rastafari influence.	Beef, goat, rice and peas, chicken, vegetables, fish and lots of spices. Some avoid eating pork and pork products because of religious beliefs.	Respect for elders is encouraged. Reserved. Avoid hugging and showing affection in public. Curious and tend to ask a lost of questions.	Will try some home remedies before seeking medical help. Like to be completely informed before procedures. Respectful of doctor's opinion. Can be reluctant to admit that they are in pain. May not adhere to a fixed schedule.
Japanese Japanese	Self-praise or the acceptance of praise is considered poor manners. Family is extremely important. Behavior and communication are defined by role and status.	Food presentation is important. Fish and soybean are main sources of protein, as well a meats and vegetables (some pickled). Rice and noodles; tea; soy sauce. Often lactose-intolerant.	Use attitude, actions, and feelings to communicate. Talkative people are considered showoffs or insincere. Openness considered a sign of immaturity, lack of self-control. Implicit nonverbal messages are of central importance. Use concept of hierarchy and status. Avoid eye contact and touch.	Family role for support is important. Insulted when addressed by first name. Confidentiality is very important for honor. Information about illness kept in immediate family. Prone to keloid formation. Cleft lip or palate not uncommon. Alcohol may cause flushing. Tendency to control anger.
Jewish Many from Eastern European countries. English, Hebrew, and Yiddish. Three basic groups: Orthodox (most strict), Conservative, and Reform (least strict).	Israel is the holy land. Sabbath is from sundown Friday to sundown on Saturday. It is customary to invite other families in for Friday evening Sabbath dinner.	Orthodox and some Conservatives maintain a Kosher diet. Kosher food is prepared according to Jewish law under Rabbinical supervision. Eating of unclean animals is forbidden. Blood and animal fats are taboo (blood is synonymous with life). Do not mix meat with dairy products.	Orthodox men do not touch women, except for their wives. Touch only for hands-on care. Very talkative and known for their friendliness.	Stoic and authoritative. Appreciate family accommodation. Jewish law demands that they seek complete medical are. Donor transplants are not acceptable to Orthodox Jews, but are to Conservative and Reform. Death: Cremation is discouraged. Autopsy is permitted in less strict groups. Orthodox believes that entire body, tissues, organs, amputated limbs, and blood sponges need to be available to family for burial. Do not cross hands in postmortem care.
Korean Hangul	Family-oriented. Believe in reincarnation. Religions include Shamanism, Taoism, Buddhism, Confucianism, and Christianity. Belief in balance of two forces: hot and cold.	High fiber, spicy seasoning, rice, Kim Chee (fermented cabbage). Speak little during meal. Often lactose- and alcohol-intolerant.	Reserved with strangers. Will use eye contact with familiar individuals. Etiquette is important. First names used only for family members. Proud and independent. Children should not be used as translators due to reversal of parent/child relationship.	Family needs to be included in plan of care. Prefer non-contact. Respond to sincerity.
Mexican Spanish. People of Indian heritage may speak one of more than 50 dialects.	Predominantly Roman Catholic. Pray, say rosary, have priest in time of crisis. Limited belief in "brujeria" as a magical, supernatural, or emotional illness precipitated by evil forces.	Corn, beans, avocado, chilies, and yellow rice. Heavy use of spices.	Tend to describe emotions by using dramatic body language. Very dramatic with grief, but otherwise diplomatic and tactful. Direct confrontation is rude.	May believe that outcome of circumstances is controlled by external force; this can influence patient's compliance with health care. Women do not expose their bodies to men or other women.
Muslim Language of the country and some English	Belief on one God, "Allah," and Mohammed, his prophet. Five daily prayers. Zakat, a compulsory giving of alms to the poor. Fasting during the month of Ramadan. Pilgrimage to Mecca is the goal of the faithful.	No pork or alcohol. Eat only Halal meat (type of Kosher).	Limit eye contact. Do not touch while talking. Women may cover entire body except face and hands.	Do no force foods when it is religiously forbidden. Abortion before 130 days is treated as discarded tissue; after 130 days, as a human being. Before death, confession of sins with family present. After death, only relatives or priest may touch the body. Koran, the holy book, is recited near the dying person. The body is bathed and clothed in white and buried within 24 hours.

Culture Group and Language	Belief Practices	Nutritional Preferences	Communication Awareness	Patient Care/Handling of Death
Northern European Language of the country and some English	Similar to American customs. Protestant with large Catholic population and some Jewish. Multi-ethnic groups.	Comparable to American diet – meat, vegetables, and starches. Coffee, hot tea, and beer.	Courtesy is of utmost importance. Address by surname and maintain personal space and good eye contact.	Maintain modesty at all times. Stoic regarding pain tolerance. Death is taken quietly with little emotional expression. Patients/family tend not to question medical authority.
Southern European Language of the country and some English	Roman Catholic, Protestant, Greek Orthodox, and some Jewish.	Main meat at midday: pasta, meat, and fish with cheeses and wine. Fresh fruit. Espresso coffee.	Talkative and very expressive. Direct and to the point. Extroverted. Good eye contact. Like personal and physical contact: holding hands, patting on back, and kissing.	Educated, yet reluctant to get medical attention. Very independent. Birth control and abortion are accepted in some countries and not in others. The whole family is involved in care of ill family member.
Samoan Samoan, English	Christian 99.7%. Religion plays important role. Believe that outcome of medical treatment, both western and traditional medicine, is a manifestation of the healing power of God through intervention of human prayers. Children seen as gifts of God. Big families are valued.	Traditional food derives mainly from tropical crops, root vegetables, coconut products, fresh fruit, pork, chicken, and seafood. Adoption of westernized eating habits has caused increase in obesity and diabetes.	Shy and tend not to ask questions or question a health professional's authority. Tend to say they understand even if they do not and will often give you the answer you want to hear rather than the truth. Samoans are very tradition-oriented; culture is steeped in complex set of social hierarchies, courtesies and customs. Respect, modesty, politeness, and humility are valued.	Facilities should assign health providers of the same gender. If western medicine is perceived as ineffective, Samoans may use traditional healers. Prayer is important part of the healing process and often seen as final solution to a health problem. Relatives are use to being allowed to be with patient at all times. When a patient is dying, it is important to let relatives have as much time with them as possible. Many Samoans believe that illness is caused by demons, a curse, or past wrongdoing. Mental health issues are not easily talked about due to stigma and shame.
Vietnamese Vietnamese language has several dialects. Also French, English, and Chinese	Family loyalty is very important. Religions include Buddhism, Confucianism, Taoism, Cao Di, Hoa Hoa, Catholicism, and occasional ancestral worship. General respect and harmony. Supernatural is sometimes used as an explanation for disease.	Rice often with green leafy vegetables, fish sauce added for flavor. Meat used sparingly and cut into small pieces. Tea is main beverage. Often lactose- and alcohol-intolerant.	Communication – formal, polite manner; limit use of touch. Respect conveyed by nonverbal communication. Use both hands to give something to an adult. To beckon someone, place palm downward and wave. Don't snap your fingers to gain attention. Person's name used with title, i.e., "Mr. Bill," "Director James." "Ya" indicates respect, no agreement.	Negative emotions conveyed by silence and reluctant smile; will smile even if angry. Head is sacred – avoid touching. Back rub – uneasy experience. Common folk practices – skin rubbing, pinching, herbs in hot water, balms, string tying. Misunderstanding about illness – drawing blood seen as loss of body tissue; organ donation causes suffering in next life. Hospitalization is last resort. Flowers only for the dead.

(Note: This chart was developed by the culture connection, a continuous quality improvement team at South Miami Hospital that eventually evolved into the culture committee. This chart is hung in the various departments around the hospital as a quick reference tool for health care personnel in their dealings with patients from different cultures. The culture tool is the result of a cooperative effort by hospital employees who represent the various cultures mentioned. The hospital welcomes input from other health care organizations so it can add information about additional cultures and languages. Reprinted with permission of Carol Biggs, South Miami Hospital.)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 10/05 **SUBJECT:** Joint Providership/Co-Providership

REVISION DATE: 05/09; 08/12; 09/14~~05/08; 04/09; 07/12; 7/14~~ **POLICY NUMBER:** 8710-602

Department Approval:	07/18
Continuing Medical Education Committee Approval:	04/09; 07/12; 08/14; 07/18
Medical Executive Committee Approval:	05/09; 08/12; 09/14; 08/18
Professional Affairs Committee Approval:	n/a
Administration Approval:	08/18
Board of Directors Approval:	05/09; 08/12; 09/14

A. **PURPOSE:**
1. To outline criteria utilized for Joint Providership or Co-Providership of a CME activity.

B. **DEFINITIONS**:
1. Joint Providership– A relationship between an accredited CME provider and a non-accredited provider in which the accredited provider works in partnership with the non-accredited provider to plan and present CME activities in accordance with the mission of the accredited provider.
2. Co-Providership– A relationship between two accredited CME providers to plan and present CME activities.

C. **POLICY**:
1. The non-accredited organization should have as its primary interest the dissemination of health care information or the findings of medical research.
2. The non-accredited organization agrees to follow all procedures outlined by Tri-City Medical Staff and contained in the CME Policy Manual.
3. The Course Director should be a physician with an affiliation in the non-accredited organization.
4. The program planning request should be received at least six (6) months before the scheduled date of the activity. Timing for the activity should not conflict with other CME activities sponsored by Tri-City Medical Center.
5. Tri-City Medical Center CME planning forms are to be completed and submitted as part of the course file.
6. All promotional material shall follow Tri-City Medical Center's CME policies and be submitted for approval to the CME Coordinator before being distributed. Appropriate accreditation statements will be used and all materials must indicate joint sponsorship with Tri-City Medical Center CME as the accredited sponsor.
7. A course coordinator should be designated by the non-accredited organization to manage the administrative details.
8. All potential joint/co-providership relationships will be examined on their individual merits. Although all CME activities joint/co-providership with Tri-City Medical Center CME must comply with this policy, Tri-City Medical Center CME reserves the right to refuse to enter into a joint/co-providership agreement for any reason whatsoever, regardless of that organization's willingness to comply with this policy.
9. The responsibilities and role of the joint/co-provider will be clearly delineated in a letter of agreement between the joint/co-provider and Tri-city Medical Center CME. Tri-City Medical Center CME has the right to withdraw from any activity if the joint/co-provider fails to meet its obligations as described in the letter of agreement or fails to comply with Tri-City Medical Center CME policies and procedures.

10. Tri-City Medical Center CME will charge fees for its services. These fees and the terms for its payment will be mutually agreed upon and delineated in the aforementioned letter of agreement between Tri-City Medical Center CME and the joint/co-provider.
11. All commercial support for Joint/co-provider activities shall be obtained as unrestricted grants, and all aspects of commercial support should be disclosed prior to approval of the activity. The CME Coordinator acting in behalf of the CME Committee will administer commercial support.
12. Joint provider activities shall be consistent with Tri-City Medical Center's CME Mission Statement.
13. Tri-City Medical Center, through its CME Committee, shall participate in the planning and implementation of these activities. A representative from the non-accredited entity should attend the CME Committee meeting to discuss progress.
14. All activity expenses are the responsibility of the organization seeking joint providership. Evidence of a proposed neutral budget is to be completed before expenses are incurred. Tri-City Medical Center will withdraw from an activity if resources are inadequate for the development of a high quality educational product or activity.
15. Attendance information should be submitted to the CME Coordinator within two (2) weeks of the activity in order to provide timely distribution of CME certificates.
16. The proposed CME activity CANNOT be advertised prior to CME Committee approval and the designation of CME credit.

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

1. Written Agreement for Joint Providership - **Sample**

Written Agreement for Joint Providership - Sample

Tri-City Medical Center
Written Agreement for Joint Providership

Program Title: _____
Program Date: _____
Program Representative(s): _____

Tri-City Medical Center and **[INSERT NAME]** agree to enter into a joint providership arrangement, the terms and conditions of which are to plan and implement the above referenced CME activity. This agreement is effective until such time as all responsibilities outlined herein are fulfilled.

As part of the Joint Providership Agreement, Tri-City Medical Center and **[INSERT NAME]** agree to the terms and conditions described below.

Role of the Accredited Provider
As the accredited provider of the CME activity, Tri-City Medical Center will take all actions necessary to ensure compliance with the Essentials for Accreditation and Standards for Commercial Support of Continuing Medical Education. Any action not explicitly stated here, but deemed necessary by Tri-City Medical Center to comply with these requirements, will be implemented.

Role of the Non-Accredited Provider
As the non-accredited joint provider of the CME Activity, [INSERT NAME] will abide by all policies and procedures set forth by the Accredited Provider including the ACCME Standards of Commercial Support with regard to product promotion and location of exhibits.

Educational Program Development
a) Tri-City Medical Center is responsible for ensuring that the content, quality, and scientific integrity of the CME activity are compliant with currently adopted standards for continuing medical education.
b) All planning sessions must be documented by the organization and all such information forwarded to Tri-City Medical Center upon completion of the program.
c) Learning objectives must be developed for each presentation and must be printed on all promotional brochures.

Tri-City Medical Center assumes responsibility for:
a) Verifying the needs assessment approving the program content, objectives, and proposed faculty in consultation with the organization (or joint provider)
b) Reviewing site selection
c) Overseeing development of brochures and promotional materials
d) Awarding appropriate CME credits
e) Maintaining records

Program budget and funds administration must be approved by Tri-City Medical Center.

Tri-City Medical Center will provide the necessary materials for obtaining:
a) Speaker disclosure
b) Learning objectives
c) Speaker A/V requirements
d) Program evaluation

Promotional Materials
a) The content of all brochures and promotional materials must be reviewed and approved by Tri-City Medical Center. Tri-City Medical Center must be listed on all materials as the joint provider. No materials pertaining to the CME activity will be distributed without the review of all parties and the consent of Tri-City Medical Center.
b) All continuing medical education program announcements must include the following language:
*This activity has been planned and implemented in accordance with the Institute for Medical Quality and the California Medical Association's CME Accreditation Standards (IMQ/CMA) through the Joint Providership of Tri-City Medical Center and [INSERT NAME]. Tri-City Medical Center is accredited by IMQ/CMA to provide continuing medical education for physicians. Tri-City Medical Center designates this educational activity for a maximum of **[NUMBER]** hour in AMA PRA Category 1 Credit™ toward the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.*

Tri-City Medical Center
Written Agreement for Joint Providership

c) No statement of credit can be printed in the materials or promotional mailings without notification from Tri-City Medical Center that credit has been awarded. Do not state: "CME credit applied for" or similar wording.

Educational Program Evaluation
All educational activities must be formally evaluated. Tri-City Medical Center will provide a sample evaluation instrument. An evaluation summary, prepared by the joint provider, will be forwarded to Tri-City Medical Center CME committee for its review within two weeks of the activity.

Disclosure of Financial Interests and Off Label Uses
Tri-City Medical Center requires the financial disclosure of any significant financial interest or other relationship that a faculty member has with the manufacturers of any commercial product(s) discussed in the educational presentation. All faculty members are required to comply and will not be able to participate in the educational activity unless they do so. Faculty members are also required to disclose if the product being addressed is not labeled for the use under discussion. Compliance that this disclosure has taken place must be documented. ***This information must be disseminated to all program participants.***

Financial Management
Non-accredited organization **[INSERT NAME]** will be responsible for all costs associated with the planning, development and presentation of the program, including but not limited to advertising, speaker fees, speaker handouts and catering costs.

Agreed by Authorized Representatives

Signature / Date	Signature / Date
Print Name	Print Name
Title	Title

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**07/01**	**SUBJECT:**	**Medical Record Documentation Requirements**
REVISION DATE:	**07/07, 03/08, 09/08, 06/09, 09/09 11/09, 07/11, 05/12, 08/12, 02/15, 12/15, 02/18~~07/18~~**	**POLICY NUMBER:**	**8710-518**

Department ~~Review~~Approval:	**~~11/17~~07/18**
Medical Executive Committee Approval:	**~~11/17~~07/18**
Professional Affairs Committee Approval:	**~~02/18~~n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**02/18**

A. PURPOSE:

1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. POLICY:

1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. RESPONSIBILITIES:

1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration~~,~~ **in conjunction** with **the** medical staff ~~approval~~, will determine the criteria for ~~current~~**timely**, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor ~~records to aid the physicians and other medical services in the Medical Center in trying~~ to ensure that medical records meet the requirements for completeness as set in this policy.

D. PROCEDURE:

1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports ~~for transcription~~ will be transcribed into the Medical Records ~~Chartscript~~ transcription system. Upon ~~completion of~~ transcription the report will be saved and sent electronically to the Cerner ~~system (Clinical Notes folder).~~**electronic medical record (EMR).**
   d. Paper-based documents will be scanned to the ~~Clinical Notes section in Powerchart (Cerner)~~**EMR** and will be ~~signed electronically, if not already signed~~**assigned by HIM for signature when required.**
   ~~e. The Report Status in Cerner will be reflected as "Transcribed"~~
      ~~i. Transcribed status reflects that the dictating physician has not yet authenticated the document.~~
   e. Physicians will utilize the Cerner Message Center ~~function~~ to authenticate transcribed **and in progress** documents in a timely manner.

f. **Electronic signature of transcribed and scanned reports by the practitioner will update the medical records/health information profile system to eliminate the signature deficiency assigned by the department.**

g. The Message Center feature supports the following actions to be taken by the physician:

i. Sign/Review

1) Physician reviews the ~~transcribed/scanned~~ document and selects the OK button that updates the status of the report ~~from "Transcribed"~~ to "Auth ~~(Verified)."~~**enticated**

2) Only the responsible physician is eligible to sign a transcribed report.

a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.

b) Resident reports will be signed by the supervising physician.

c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician **within 48 hours but prior to patient discharge in the acute care setting**~~.~~

ii. Modify/Sign

1) Physician may modify the ~~transcribed~~ document PRIOR to signature to correct/clarify any elements of the report.

2) ~~Modifications~~ **Addendums** are to follow the structure of new information being bolded and deleted information noted as a strike-through

3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse

1) Physician **may refuse and redirect a document** ~~identifies that he/she is not responsible for the report as well as a reason for refusal and redirects the report~~ to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician **via Cerner message center**.

~~2) Electronic signature of the transcribed and scanned reports by the physician will update the Medical Records/Health Information Profile system to eliminate the signature deficiency assigned by the department.~~

2. Written Signatures

a. It is expected that ~~all~~ members of the medical staff **and allied helath** will utilize acceptable written signatures, including credentials ~~(e.g., MD, PA, NP, CNM)~~ for all paper**-based** documents being authenticated.

i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, **same-**day surgery, **observation,** and inpatient documentation.

b. Acceptable written signatures are as follows:

i. Legible full signature

ii. Legible first initial and last name

iii. Illegible signature over a typed or printed name

iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer

1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.

v. Initials over a typed or printed name

vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed

c. Unacceptable written signatures are as follows:

i. Signature stamps alone **are not acceptable.**

~~1) These are not recognized as valid authentication for Medicare signature purposes and may result in payment denials by Medicare.~~

ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
iii. Unsigned typed note with provider's typed name
iv. Unsigned typed note without provider's typed/printed name
v. Unsigned handwritten note, the only entry on the page

3. The following criteria must be met before a chart is considered complete:
   a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
      i. Identification data
      ii. Legal status if mental health patient;
      iii. Emergency care given prior to arrival if any;
      iv. Findings of assessment;
      v. Conclusions or impressions from history and physical;
      vi. Diagnosis or diagnostic impression;
      vii. Reasons for admission or treatment;
      viii. Goals of treatment and treatment plan;
      ix. Known advance directives;
      x. Informed consent for procedures and treatment;
      xi. Diagnostic and therapeutic procedures and tests and their results;
      xii. Operative and other invasive procedures performed;
      xiii. Progress notes;
      xiv. Reassessments if needed;
      xv. Clinical observations;
      xvi. Response to care;
      xvii. Consultation reports;
      xviii. Every medication ordered; every dose administered and any adverse reaction;
      xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
      xx. All relevant diagnoses established during care;
      xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the ~~person~~ **practitioner** responsible for providing or evaluating the service provided.
   a. All ~~handwritten~~ documentation is to be without the use of Do Not Use Abbreviations.
      ~~i. A reference of Do Not Use Abbreviations is available in multiple locations.~~
         ~~1) Physician Order Forms~~
         ~~2) Progress Notes~~
      ~~ii.~~i. ~~TCMC Intranet – Administrative Policy 367~~**referenced on the TCMC intranet.**

5. History and Physical
   a. A complete history and physical examination shall be present in the medical record no more than 30 days before or within twenty-four (24) hours of admission.
      i. ~~Legible, H~~handwritten history and physicals are ~~acceptable provided they meet the documentation requirements.~~**not acceptable and an electronic or printed H&P must be provided.**
      ii. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
      iii. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
      iv. For patients with H&P's not more than 30 days old (in lieu of a new H&P), an examination of the patient, including any changes in the patient's condition, must be present in the medical record within 24 hours of admission.

v. A history and physical completed more than 30 days prior to admission is not valid and must be completed.
vi. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.

b. The history and physical shall include the following elements:
i. Chief complaint;
ii. Personal, past medical and surgical history;
iii. Allergy history;
iv. Current medications;
v. Family history;
vi. History of present illness;
vii. ~~All important~~**All-important** findings resulting from a review of systems;
viii. Physical examination;
ix. Diagnosis or diagnostic impression;
x. Plan of treatment.

c. Surgeries or procedures requiring anesthesia services must have a history and physical present in the medical record, no older than 30 days.
i. Physician Pre-Procedure Documentation including an update to the H&P must be recorded on the patient's medical record on the same day, prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed.
ii. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:
1) H&P was completed
2) H&P was reviewed
3) The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.
iii. When the required history and physical examination is not present before the time stated for the operation, the operation shall be postponed until the history and physical is present in the medical record or the physician has documented that such a delay would constitute a hazard to the patient.

d. History and physical for hospital outpatient procedures:
i. Ambulatory surgery patients undergoing invasive procedures with anesthesia, procedural sedation, ~~patients with an American Society of Anesthesiologists (ASA) classification greater than 2,~~ or procedures that could compromise the circulatory or respiratory status **as determined by the practitioner,** shall have a complete H&P as defined above prior to surgery.
ii. Hospital outpatients undergoing invasive procedures without a significant level of risk shall have at least a limited history and physical.
iii. A limited history and physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.

6. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.
a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.
b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical

problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.

i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

7. Medication reconciliation:
   a. Admission
      i. The admitting physician is required to review, complete and reconcile admission medication reconciliation information in Cerner collected upon admission of the patient within 24 hours.
      ii. If new information is later obtained, the ~~physician or nurse~~**clinician** may update the medication by history list in Cerner.
   b. Transfer
      i. All medications will be reviewed and revised as appropriate when patient is being transferred to another level of care.
         1) Electronic Orders
            a) The physician will access the transfer medication reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.
   c. Discharge
      i. All medications will be reviewed against HOME medications in Cerner.
         1) Electronic Orders
            a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
            b) Prescriptions to be completed
               i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
               ii) Printed on the unit and handed to the patient
               iii) Handwritten on personal (physician's) prescription pad
         2) Written Orders
            a) Physician handwrites prescriptions on personal (physician's) prescription pad.
            b) Physician updates physician medication changes on the electronic medication list through the medication reconciliation tool.

8. Daily progress notes must be document~~ed~~**ed and reflect medical care and visitation of the patient** by the attending member on all ~~acute~~ patients in the hospital.
   ~~a. Progress notes for Behavioral Health unit patients, will be written six days per week by the attending member.~~
   ~~b.~~**a.** All ~~members of the medical staff~~**practitioners** will document progress notes in any of the following methods:
      i. ~~Written~~ **Hand-written** ~~on the~~ progress notes ~~form placed in the patient's active record~~**are not acceptable;**
      ii. **An e**~~E~~lectronic note may be a progress note typed by the physician or a progress note generated using a voice recognition software application (e.g. Dragon).
   ~~c. All progress note entries shall be timed, dated, and electronically signed by the physician recording the note. Electronic notes shall be signed electronically.~~
      ~~i. The electronic progress note shall not be printed, signed and placed in the hard copy chart (this is duplicate documentation that may require both documents to be maintained in the legal record (i.e. scan document as well as maintain electronic version).~~
   ~~d.~~**b.** Progress notes recorded by ~~Residents and/or Physician Assistants~~**mid-level providers**

are required to be co-signed by the ~~attending~~ **supervising** physician member **within 48 hours but prior to patient discharge.**~~.~~

~~e. Interdisciplinary notes recorded by the other care providers are available in the Cerner system for review by the physician.~~

~~f.~~**c.** ~~These notes are recorded by non-physicians within the Power Note application in the Cerner system.~~

~~g. Physician evaluation of Occupational Health patients (Work Partners) and Wound Care Center patients may result in an electronic note captured directly into the Cerner system.~~

~~i. Voice recognition software may be utilized by practitioners in these areas to generate a note summarizing the patient's history, assessments, and treatments.~~

~~ii. These notes will be authenticated by the examining physician and will be displayed as part of clinical notes.~~

~~9. Consent for Photography will be obtained from the patient when a patient will be photographed while receiving treatment at the Medical Center. The term "Photograph" includes video or still photography, in digital or any other format, and any other means of recording or reproducing images.~~

~~10.~~**9.** All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.

a. The informed consent documented will include the following:
   i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
   ii. The likelihood of the patient achieving his or her goals.
   iii. Any potential problems that might occur during recuperation.
   iv. Reasonable alternatives including side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
   v. Name of the ~~person~~**practitioner** who will ~~carry out~~**perform** the proposed care, treatment, and services.

~~11.~~**10.** Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.

~~12.~~**11.** A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.

~~13.~~**12.** A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient and shall include:

a. Respiratory function including rate, airway patency and oxygenation saturation;
b. Cardiovascular function, including pulse rate and blood pressure;
c. Mental status;
d. Temperature;
e. Pain;
f. Nausea and vomiting;
g. Anesthesia complications;
h. Post-operative hydration; and
i. Additional types of monitoring and assessment as may be necessary.

~~14.~~**13.** Operative or other high risk procedure reports shall be completed electronically or dictated immediately after surgery and shall include:

a. Pre-operative diagnosis;
b. Post-operative diagnosis;
c. Date of procedure

i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
ii. Name of procedure;

d. Anesthesia type;
e. A detailed account of the procedure including approach and technique used;
f. Estimated blood loss **if any**;
g. Specimen removed **if any**;
h. Name of the primary surgeon and any assistants;
i. Complications;
j. Patient status;

~~15.~~**14.** A post-operative/procedure n~~N~~ote shall be completed immediately following surgery or other high-risk procedures when the operative/procedure report is dictated pending transcription. An operative note is not required if the operative/procedure report is completed electronically and immediately available in the medical record. Use of the electronic post-operative procedure note is necessary to document all required elements.

a. Name of Procedure;
b. Pre-Operative diagnosis
c. Post-Operative diagnosis
~~d.~~ Patient status
~~e.~~**d.** ~~Estimated blood loss~~
~~f.~~**e.** Name of primary surgeon and any assistants
~~g.~~ Anesthesia type
~~h.~~**f.** ~~Specimen collected~~
~~i.~~**g.** Complications
~~j.~~**h.** Findings

~~16.~~**15.** When the operative note is dictated, the electronic p~~P~~ost-o~~O~~perative n~~N~~ote must be completed by the surgeon prior to the patient being discharged or transferred from ~~PACU~~**recovery**.

~~17.~~**16.** An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:

a. Name and hospital ID number of the patient
b. Name of anesthesiologist who administered the anesthesia
c. Vital signs reflecting patient status just prior to induction
d. Name, dosage, route, and time of administration of drugs and anesthesia agents
e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
f. Names and amounts of IV fluids, including blood or blood products
g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

~~18. The electronic Post must be completed, when the operative report is dictated.~~

~~19.~~**17.** All orders, including verbal orders, must be dated, timed, and authenticated.

a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

~~20.~~**18.** Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.

~~21.~~**19.** It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.

a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders **electronically** into Cerner~~ or in writing~~.
b. All orders for treatment shall be entered electronically to the medical record. An order for

treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.

c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
   i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
   ii. Vaccines
   iii. Intravenous fluids
   iv. Medication doses that if weight based would equal or exceed normal adult doses.

~~22.~~**20.** When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
   a. Electronic Orders
      i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
      ii. Complete the Transfer Medication Reconciliation function
   ~~b. Written Orders~~
      ~~i. Rewrite all orders.~~
      ~~ii.~~**iii.** The physician is not required to ~~rewrite~~ **re-enter** orders when a patient is undergoing one of the following minor procedures and returns to the same level of care:
         1) Heart Catheterization
         2) Interventional procedures including PICC line placement
         3) Endoscopy including bronchoscopies
         4) Inpatient dialysis
         5) Pain management

~~23.~~**21.** Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.

~~24. Current obstetrical records shall include complete prenatal records, including a copy of the actual lab reports. The prenatal record may be a legible permanent copy of the attending practitioner's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.~~

~~25. All patients evaluated by an Emergency Department physician are to have a documented report outlining the history of present illness, assessment, and treatment rendered.~~
   ~~a. Records for patients evaluated by both a resident and an ED physician will include documentation by each of the evaluators. The attending ED physician is responsible for authenticating ED reports dictated by a resident.~~
   ~~b. Records for patients evaluated by an ED Physician Assistant (PA) will include only documentation by the PA which will be authenticated/signed by both the PA and ED supervising physician.~~

~~26. All clinical entries in the patient's medical record shall be accurately dated and authenticated.~~

~~27.~~**22.** Discharge/Depart Process
   a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
   b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
      i. Nursing will enter into the Depart Process application
      ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)

~~28.~~**23.** A Discharge Summary shall be ~~dictated~~ **completed** for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:

a. Discharge Diagnosis
b. Reason for hospitalization
c. Significant findings
d. Procedures performed and treatment given
e. Condition on discharge
f. Instructions given to the patient or patient representative
    i. Follow-up instructions
    ii. Diet instructions
    iii. Discharge medications
g. A ~~written or dictated~~ discharge note is acceptable for all patients with a length-of-stay less than forty-eight (48) hours, to include normal obstetrical deliveries, and normal newborn infants.
    i. Requirements of the **n**~~N~~ote include:
        1) Discharge **d**~~D~~iagnosis
        2) Instructions given to the patient or patient representative:
            i. Follow-up instructions
            ii. Diet i~~I~~nstructions
            iii. Discharge m~~M~~edications
        3) Physicians ~~having a Discharge Summary that requires~~**who have not completed a discharge summary at the time of discharge** ~~,dictation completion~~ will be notified **by Medical Records/HIM** via the Message Center in Cerner **and call to their office.** ~~All physicians will be required to complete all pending dictations and/or signature deficiencies within 14 days of patient discharge.~~

~~29.~~**24.** Physicians will be notified of **all pending dictations and/or signatures** ~~outstanding charts requiring signature~~ via their **Cerner** Message Center **and** ~~as well as via letter and~~ call to their office.

a. Physicians will be suspended **if the chart is not completed within 14 days of discharge** per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).

~~30.~~**25. Late entries, addendums or corrections to the medical record** ~~Late Entry~~

a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a **late entry, addendum, or correction** ~~late entry~~ will be made with the following required elements documented:
    i. **A late entry, addendum or correction to the medical record, bears the current date of the entry and is signed by the person making the change or addition to the medical record.** ~~The date and time of the observation A note clearly identifying the documentation as "Late Entry"~~
    ii. **A late entry supplies additional information that was omitted from the original entry. A late entry bears the current date and is added as soon as possible after the original entry was entered.**
    iii. **An addendum is used to provide information that was not made at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.**
    ~~ii.~~**iv. When making a correction to the medical record, the original entry must remain viewable. Documentation of the correct information should contain the current date and time and reference back to the original entry.**
b. It is not permitted to have entries "backdated" or "predated".
c. The chart shall be completed within fourteen (14) days of discharge; it is expected no

late entries will appear after this time period.

E. FORM(S):

1. Electronic Signature Certification Statement - Sample

SAMPLE

Tri-City Medical Center

ELECTRONIC SIGNATURE CERTIFICATION STATEMENT

The purpose of this form is to certify that each physician identifier is kept confidential. This form also certifies that Tri-City Medical Center is committed to maintaining the confidentiality of the physician identifiers. If it is determined that an assigned identifier has been misused, the authorized hospital official will terminate a physician's use of his or her identifier.

The term 'misused' is defined to mean that the physician has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse must be documented by the authorized hospital official and actions to terminate the use of the physician identifier must be initiated immediately, including written notice to the physician involved.

PHYSICIAN CERTIFICATION:
I certify I will not disclose the identifier assigned to me to any other person or permit another person to use it.

_____ _____
Physician Signature Date

_____
Physician Name (Printed)

TRI-CITY MEDICAL CENTER CERTIFICATION
I certify that the identifiers assigned to physicians for purposes of the Compass Physician Inbox electronic signature process will be kept confidential and that I will terminate the use of a physician's identifier in the event that he or she misuses it.

_____ _____
TCMC Authorized Representative Date

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME) ~~POLICY MANUAL~~

ISSUE DATE: 4/09 **SUBJECT:** Regularly Scheduled Series (RSS)

REVISION DATE: 12/09; 11/12; 09/14~~10/09; 10/12; 7/14~~ **POLICY NUMBER:** 8710-606

Department Approval:	**07/18**
Continuing Medical Education Committee Approval:	**10/09; 10/12; 08/14; 07/18**
Medical Executive Committee Approval:	**11/09; 11/12; 09/14; 08/18**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	**12/09; 11/12; 09/14**

A. **PURPOSE:** To outline criteria and process for approving and evaluating outcomes for Regularly Scheduled Series (RSS).

B. **DEFINITION**: A regularly scheduled Series (RSS) is planned to have:
1. A series with multiple sessions
2. The series occurs on an ongoing basis (offered weekly, monthly, or quarterly)
3. The series is planned by and presented to the accredited organization's professional staff
4. The series are only offered as directly-sponsored activities to the accredited organization's professional staff

C. **POLICY:**
1. RSS conferences such as cancer conferences and cardiovascular conferences are approved on the basis of common needs and goals for each session for a one-year period.
2. **INITIAL RSS REQUEST:** Required documentation to be provided to the CME Committee at least 60 days before the first session is scheduled:
   a. *Request for AMA PRA Category 1 Credit(s)™*
   b. *Planner and Faculty disclosure* forms
3. **CONTINUING RSS**: For regularly scheduled series conferences currently taking place with Category 1 credit, the planner shall submit on an annual basis to the CME Coordinator the *Annual Evaluation and Outcomes* form and a new *Request for AMA PRA Category 1 Credit(s)™* and *Faculty Disclosure* form(s). *A* 60-day time frame for CME Committee review is encouraged.
4. **CONFERENCE PLANNER**: The conference planner is responsible for providing the following documentation to the CME Coordinator within 30 days of the session date:
   a. Session Case Selection & Outcomes form
   b. Completed evaluation forms
   c. Evaluation summary
   d. Attendance roster
   e. Case summaries (if applicable)
   f. Copy of promotion materials (flyer)
5. Regularly scheduled series conferences must be at least 50 minutes in length for one (1) category 1 credit.

D. **EVALUATION – IMPROVEMENT:**
1. Learners will complete an annual RSS *Learner Evaluation* form. Results will be summarized and provided to the CME Committee.

E. **REFERENCE:**

1. Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014 CME Accreditation Criteria and Policies for Continuing Medical Education (CME) * with annual report.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 04/08

SUBJECT: Tuberculosis Screening of Licensed Independent Practitioners and Allied Health Professionals

REVISION DATE(S): 05/08, 08/12

POLICY NUMBER: 8710 – 538

Department Approval:	~~07/17~~05/18
Infection Control Committee Approval:	~~10/17~~07/18
Credentials Committee Approval:	01/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	07/18
Professional Affairs Committee Approval:	n/a
Administration Approval:	08/18
Board of Directors Approval:	

A. **PURPOSE:**

1. Screening for tuberculosis provides a mechanism to detect latent or active disease. This will facilitate treatment and appropriate follow-up to decrease the risk of transmission within Tri-City Health District.

B. **SUPPORTIVE DATA:**

1. Tri-City Medical Center falls into the Department of Health and Human Services 'medium-risk classification' as defined in the Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005. Facilities in this category should perform baseline and annual TB screening for all healthcare workers who might have contact with persons with suspected or confirmed TB disease. JCAHO Standard IC.4.10 also requires interventions to reduce the risk of infection, specifically, "testing of licensed independent practitioners (e.g. physicians and allied health professionals)".

C. **POLICY:**

1. All licensed independent practitioners are required to complete initial appointment, pursuant to § 4.5-1 of the Medical Staff Bylaws, application for initial appointment and reappointment and annual screening for Mycobacterium tuberculosis. Failure to comply with this requirement will result in the initial application being deemed incomplete and, for current staff members, pursuant to § 6.3-5, of the Medical Staff Bylaws, limited suspension of clinical privileges.
2. An individual's requirement to fulfill screening will depend upon previous testing results (See **Tuberculosis Testing for LIPs**~~Appendix A.~~)
3. The QuantiFERON-TB®-Gold (QFT-G) is a blood test that measures interferon-gamma release from sensitized white blood cells and may be used in any situation which calls for a tuberculin skin test (TST). Unlike the TST, it does not require two-step testing and does not cross-react with Bacillus Calmette-Guérin (BCG). However, whereas the TST is offered free of charge, physicians electing to obtain a QFT-G will have to pay for the test (approximately $50) though the hospital can assist with the venipuncture and transport of the specimen to an appropriate facility.

D. **PROCEDURE:**

1. Medical Staff Office provides LIPs with a tuberculosis screening form (**MD Tuberculosis Annual Attestation Form**~~Appendix B~~) at the time of initial appointment.

2. Completed forms are stored in the individual's credentials file.
3. WorkPartners Occupational Medicine establishes an annual tuberculosis screening date for tracking.
4. Workpartners is responsible for sending reminder letters to the LIP on an annual basis.
5. Delinquent LIP's reappointment packets are considered incomplete and all clinical privileges shall be subject to suspension per bylaws if requirements are not met.

E. RELATED DOCUMENT(S):

1. **Tuberculosis Testing for LIPs**
2. **MD Tuberculosis Annual Attestation Form**

F. REFERENCE(S):

1. **CDC Draft Guidelines for Preventing the Transmission of M.tb in Health-Care Settings, 2005 http://www.cdc.gov/nchstp/tb/Federal_Register/New_Guidelines/TBICGuidelines.pdf**
~~6.~~2. **CAHM Comprehensive Accreditation Manual for Hospitals: the Official Handbook, Refreshed Core, January 2005**

~~**Approvals:**~~
~~**Infection Control Committee Approval: 07/12**~~
~~**Credentials Committee Approval: 08/12**~~
~~**Medical Executive Committee Approval: 08/12**~~
~~**Board of Directors Approval: 05/08; 08/12**~~

~~APPENDIX A~~

Tuberculosis Testing for LIPs

Situation	Recommended Testing
No previous or unknown tuberculosis skin test (TST) result	Two-step baseline TST
No previous or unknown TST and previous vaccination with BCG	Two-step baseline TST or single QuantiFeron Gold (at physician's expense)
Previous single negative TST result (documented or not) more than 12 months prior to credentialing application	Two-step baseline TST
Previous documented single negative TST result ≤ 12 months prior to credentialing application	Single TST needed for baseline testing. This test will serve as the 2nd of a two-step procedure.
Two or more previous documented negative TSTs with the most recent TST more than 12 months prior to credentialing application.	Single TST; two step testing not necessary
Two or more previous documented negative TSTs with the most recent TST less than 12 months prior to credentialing application	Continue yearly testing
Baseline positive or newly positive TST or documentation of previous treatment for latent tuberculosis infection or diseases	1. CXR to exclude active disease (yearly CXRs NOT required.) 2. Annually complete an attestation that you are free from symptoms of infectious disease

~~APPENDIX B~~

MD Tuberculosis Annual Attestation

Please Print Name: _____ Date: _____

Tuberculosis (PPD) Skin Test

Date Placed	Dose	Site	Placed by	Date Read	Results (mm induration)	Read by
	Purified Protein Derivative 5TU 0.1mL intradermal	Lt. Forearm Rt. Forearm				

A second skin test is needed to be placed 7-21 days after the first skin test if:

- No previous or unknown tuberculosis skin test (TST) result
- Previous single negative TST result (documented or not) more than 12 months prior to credentialing application

Date Placed	Dose	Site	Placed by	Date Read	Results (mm induration)	Read by
	Purified Protein Derivative 5TU 0.1mL intradermal	Lt. Forearm Rt. Forearm				

OR

QuantiFERON-TB test (QFT) completed and results _____

AND

I do not have any of the following symptoms and believe that I am not infectious.

Unusual fatigue for longer than two weeks.

Weight loss unrelated to dieting.

Loss of appetite for longer than two weeks.

Persistent cough longer than two weeks.

Hemoptysis.

Fever with cough for longer than two weeks.

Night sweats.

Please Sign Name: _____

Fax (760) 940-3299
Mail Medical Staff Office: Attention Credentialing
Tri-City Medical Center
4002 Vista Way
Oceanside, California 92056

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: NEW

SUBJECT: Cleaning and Sanitizing of Specialty Bottles/Nipples

REVISION DATE(S):

Department Approval:	**04/18**
Perinatal Collaborative Practice Approval:	**05/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Infection Control Committee:	**07/18**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval:	

A. **DEFINITION(S):**
1. Specialty Bottle/ Nipple: Bottle/ Nipple used for therapy intervention or bottle brought by parent from home to utilize for feedings.
2. Feeding System: all parts of specialty bottle/nipple.
3. Therapy Department: Includes Occupational Therapy and Speech/Language Pathologist/Speech Therapy who evaluate infant feeding coordination, swallow, development, etc.

B. **POLICY:**
1. A Specialty Bottle/Nipple may be provided and/or prescribed for use by Therapy Department.
2. A Specialty Bottle/Nipple may be brought from home to utilize for transitioning an infant to a non-hospital bottle for home feedings.
   a. Prior to use, feeding systems brought from home should be approved by Neonatologist or Therapy Department.
3. Abrasive and antiseptic cleansers should not be utilized for cleaning feeding systems.
4. Bottles, brushes and nipples will be washed with food grade soap and water in an approved basin after each use.
   a. Cleaning of bottles should be done in designated area.
   b. Feeding systems and cleaning supplies (sanitizing bags, basin, and bottle brush) are single patient use and should be labeled with patient's name with a permanent marker, and relabeled when needed due to fading.
5. Bottles, brushes and nipples should be left to air dry in a clean space at bedside. Paper towels may also be utilized for drying.
6. Reusable feeding systems will be sanitized every 24 hours.
7. **Microwave steam sanitizing bags are verified for 20 uses; Boxes are present on the bag for tracking use. Mark the date in the box after each use.**
~~6.~~**8. Small wire brushes used for cleaning the vent system are replaced at the same time as the sanitizing bags, or sooner as indicated. Do not microwave small metal brushes.**

C. **PROCEDURE:**
1. **Cleaning:**
   a. Clean system immediately following use to prevent drying/buildup of materials.
   b. Use a designated basin for cleaning feeding systems.
   c. Clean area to be used.
      i. Don gloves and use hospital grade cleaner to disinfect the work area.

d. Don clean gloves and disassemble the feeding system: including venting inserts, reservoirs, collars and discs before cleaning.
e. Rinse system parts under running water.
f. Use designated cleaning product, non-metal bottle brush, and basin to clean entire feeding system including parts by wiping and/or gently scrubbing.
   i. Ensure patency of nipple by rinsing water through the hole.
g. Thoroughly rinse all feeding system parts with running water.
h. Remove feeding system and parts from basin and place on clean, dry cloth.
i. Dump out water from basin and rinse.
j. Disinfect the basin with a designated cleaning product and allow basin to dry completely.
k. Line the basin with a clean cloth and place feeding system in the basin at the **infant's** bedside and allow items to air dry.

2. **Sanitizing:**
   a. Clean interior of microwave with hospital approved cleaner. Allow to dry.
   b. Every 24 hours, place cleaned feeding system and non-metal bottle brush into microware steam sanitizing bag, zip closed and sanitize according to product directions. (Parts do not have to be previously air dried prior to sanitizing.)
   c. Remove bag by zipped closed top to avoid burns from the steam vent on the side. Tip bag to pour hot water out of steam vent and cool before opening bag.
   d. Line the basin with a clean cloth, place feeding system in the basin at the bedside and allow items to air dry.
   e. Microwave steam sanitizing bags are verified for 20 uses; Boxes are present on the bag for tracking use. Mark the date in the box after each use.
   f. **Small wire brushes used for cleaning the vent system are replaced at the same time as the sanitizing bags, or sooner as indicated. Do not microwave small metal brushes.**
   ~~e.~~

3. **Procedure for infants in Isolation Precautions:**
   a. If infant is in isolation, steam bags should be kept on a cart/table outside of the room.

D. **REFERENCE(S):**

1. Infant Feedings: Guidelines for Preparation of Human Milk and Formula in Health Care Facilities, 2nd edition 2011, Robbins, S. T., Meyers, R., Pediatric Nutrition Practice Group, American Dietetic Association.
2. Dr. Brown's™ Microwaveable Steam Sterilizer Bag and Bottle package insert: Instructions.
3. **Suggested Guidelines for Cleaning Dr. Brown's™ Bottle Systems and Nipples in the Hospital Environment. (2016). www.drbrownsbaby.com/medical.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

DELETE- Incorporated in Patient Care Services Procedure: Release of Deceased

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 27, 1991~~ ~~Reviewed: 04/94, 12/96, 01/00, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 01/97, 7/03, 5/11~~ ~~Approvals: Director of Security~~	~~Subject: Morgue Release (Security Officer Responsibilities)~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - #224~~

SUBJECT: Morgue Release (Security Officer Responsibilities)

ISSUE DATE: March 27, 1991 **POLICY NUMBER:** 224
REVIEWED DATE(S): 04/94, 12/96, 01/00, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 01/97, 7/03, 5/11

Department Approval Date(s):	**08/15**
Environmental Health and Safety Committee Approval Date (s):	**09/15, 05/18**
Professional Affairs Committee Approval Date(s):	**n/a**
Administration Approval:	**08/18**
Board of Directors Approval Date(s):	

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

~~1. This policy is to establish guidelines for Security Officers when conducting a Morgue Release to the appropriate mortuary. Reference Patient Care Procedure: Release of Deceased.~~

~~B. **DOCUMENTS:**~~

~~1. The following documents are required prior to any Morgue Release~~

~~a. Authority for Release of Deceased.~~
~~b. Authorization for Autopsy, if requested.~~
~~c. Two copies of Face Sheet from patient's chart.~~
~~d. Donation of Organ(s) and/or Tissue(s), if necessary.~~
~~e. San Diego Eye Bank Consent for Organ Donation, if necessary.~~

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

~~1. After a patient expires the Nursing **nursing** Staff **staff** will be required to complete all necessary paperwork, and arrange the transport of the deceased patient's remains to the Morgue for the release of the remains to the proper Mortuary.~~

~~2. On Monday-Friday, between 0800hrs and 1600 hrs (excluding holidays), tThe completed paperwork will be delivered to the Nursing **Administrative** Supervisor **(AS)**. At all other times, the completed paperwork will be delivered to the Administrative Coordinator.~~

~~3. On Monday-Friday, between 0800hrs and 1600hrs (excluding holidays), tThe Patient Representative**AS** will receive **review** the paperwork and make the necessary contact with the appropriate mortuary. The Administrative Coordinator will conduct this notification process during all other times.~~

4. After a representative of Tri-City**the AS** has contacted the appropriate mortuary they will come to the loading dock and contact the PBX Operator. PBX will then notify the on-duty Security Officer. At no time will the release paperwork be given to any unauthorized personnel.
5. The responding Security Officer will:
   a. Pick up the release forms from the PBX **AS** office.
   b. Go to the Morgue entrance and make contact with the Mortuary Driver. If necessary the Security Officer may request proper ID from the Driver.
   c. Prior to any release all Security Officers will wear a single pair of rubber gloves as universal precaution.
   d. In the presence of the Mortuary Driver the Security Officer will verify all ID tags to make sure all tags match. Security Officers will identify and check the Outer Bag Tag, Toe Tag, and ID wristband. This verification will consist of the deceased's Name and Medical Record Number. If at anytime the ID's do not match the Patient Representative or Administrative Coordinator**AS** is to be notified immediately.
   e. The Security Officer will then check the deceased person's body for any jewelry or personal affects and document any on the appropriate paperwork.
   f. The Security Officer will sign, date, and time the release form and get the Mortuary Driver's signature as well.
   g. The Mortuary Driver will then be given a copy of the release as well as a copy of the patient's Face Sheet.
   h. Upon completion of the Morgue Release the Security Officer will return the completed paperwork to the PBX Office.
   i. After the release is completed, Security will notify Lift Team to move any bodies residing outside of the fridge into the open fridge unit.
   j. At this time the Security Officer will be completed with their responsibilities for the Morgue Release.
6. If at any time incomplete paperwork is discovered, the Security Officer will:
   a. Immediately contact the **AS**Patient Representative or the Administrative Coordinator and relay the problem to them.
   b. Make a detailed entry into the Officer's Daily Security Report with all facts listed.
7. At no time will any Security Officer be required to:
   a. At **NO TIME** will any Security Officer **l**Lift or attempt to lift any remains as assistance to the Mortuary Driver.
   b. No Security Officer shall be required to **T**transport a deceased patient's remains to or from the Morgue.
   c. If it is necessary to escort the Mortuary Driver to the expired patient's room, the floor's Charge Nurse or administrative coordinator**AS** will be responsible for all paperwork.
   d. No Security Officer shall be required to p**P**articipate in any other functions of a Morgue Release than stated in section 3.5 of SDPP # 224 **this policy.**
   e. No Security Officer shall be required to p**P**repare a deceased patient's body for viewing in the Morgue or any other location.

If it is necessary to escort the Mortuary Driver to the expired patient's room, the floor's Charge Nurse or AS will be responsible for all paperwork

8. All releases from the Emergency Department, other than a Coroner's Case will follow the same described procedure.

At all times the responding Security Officer will maintain a high degree of professionalism when conducting a Morgue Release.

Reference
Release of Deceased Procedure

Tri-City Medical Center
Oceanside, California

ULTRASOUND AND VASCULAR IMAGI

DELETE: Follow Patient Care Services Procedure: High Level Disinfection

ISSUE DATE: 05/11

SUBJECT: Cidex Policy for Disienfection Process for Vaginal Probe/Prostate Probe

REVISION DATE(S):

Department Approval:	08/17
Department of Radiology Approval:	06/18
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Professional Affairs Committee Approval:	n/a
Administration Approval:	08/18
Board of Directors Approval:	05/11

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

~~1. Define use of all high level disinfectant(HLD) be utilized in a safe and effective manner.~~

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

~~1. Don personal protective equipment (PPE).~~
~~2. After removal of probe cover preform cleaning of the probe. Fill the designated wash basin with one gallons of water and one pump of detergent (one pump of detergent per gallon of water) and place probe in filled basin.~~
~~3. Unlock cidex cabinet and remove lid from cidex container.~~
~~4. Note the temperature of the cidex.~~
~~5. Take one cidex test strip from test strip jar and dip strip in cidex.~~
~~6. Set aside strip and wait 90 seconds to determine if the cidex passes or fails (test strip should immediately turn purple, purple = passes, blue or speckles = failed).~~
~~7. After 1 minute remove probe from detergent/water solution and discard solution down the sink. Rinse the probe with water and dry off with soft washcloth or paper towel.~~
~~8. Place probe in cidex (securing probe cord with clip) and soak for 12 minutes. Close cidex door and lock cabinet.~~
~~9. Complete cidex log. To include patient **medical record number**, location, temperature of cidex, solution expiration date, solution test date, solution test end time, pass or fail of solution, tested by, soak time.~~
~~10. Following removal from cidex thoroughly rinse the probe. Use designated rinse basin. Fill basin with two gallons of water and keep probe immersed for a minimum of 1 minute. Repeat this process for two additional times (a total of 3). Always use fresh volumes of water with each rinse.~~
~~11. Store cleaned probe in designated locked drawer with a clean probe sign. Put the lid on the cidex and lock the cabinet. Place key in designated area.~~

~~C. **FORMS:**~~

~~1. Cidex log sheet to include temperature, **medical record number**, date, time, and initals.~~

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**NIPPLE SHIELD AND SUPPLEMENTAL NURSING SYSTEM (SNS)**
~~Purpose:~~	~~1. A **nipple shield** is used to assist the mother/baby c~~ ~~breastfeeding problem when identified by the Lactation~~ ~~Registered Nurse. Nipple shields may provide the infa~~ ~~working on a "latch-on" problem.~~ ~~2. A **supplemental nursing system** (SNS) may be us~~ ~~supplemental nutrition either in expressed breast milk or formula.~~
~~Supportive Data:~~	~~1.The nipple shield is a temporary aid to assist the baby to achieve a correct latch and suck; shields are used on flat or inverted nipples, which the infant may have difficulty latching onto. Shields are also used to correct tongue position or suck. They may be helpful for mother to use if baby has a high palate, and in some mothers, as an aid for hypersensitive and or painful, sore nipples. The use of a thin, silicone nipple shield may make breastfeeding possible for the couplet that may otherwise decide to bottle feed. Nipple shields have proven successful in transitioning the NICU baby from bottle to breast.~~ ~~2.The Supplemental Nursing System is used to give an infant supplementation either by breast milk or formula when time is needed to improve breastfeeding ability or milk supply. The low weight gain baby or the infant with a weak suck reflex can benefit from the SNS. In the situation of low milk supply a supplementation device allows a baby to continue breastfeeding when his mother is not able to produce a total milk supply.~~
~~Equipment:~~	~~1. Nipple shield – (standard 24mm or small 20 mm, or small I16mm)~~ ~~2. Medium size feeding tube~~ ~~3.1. 10-20 mL syringe or container~~

DELETE- Incorporated into Women & Newborn Services: Infant Feeds Procedure.

~~A. **PROCEDURE:**~~

~~**Application of the nipple shield:**~~

~~1. Instruct the mother to wash her hands and the nipple shield in warm/hot soapy water, rinsing well to remove soap.~~
~~2. Assess baby to be sure s/he is comfortable with size choice.~~
~~a. Sizing a shield is dependent on baby's mouth and the size of the mother's nipple.~~
~~3. Place the nipple shield under running hot water to make the shield more pliable and to enhance adherence to the breast.~~
~~a. Colostrum, or lanolin cream may also be used to help with adherence.~~
~~4. Handle the shield by the rim. Place the shield over the breast with the nipple centered inside the nipple portion of the shield.~~
~~a. Support the breast with a "C" hold. Place the thumb on top of the breast and shield and with fingers below (away from the areola).~~

~~**Latching the infant to the breast with a nipple shield:**~~

~~1. Guide mother to stroke the infant's lower lip with the shield. When the baby's mouth opens wide, bring the baby directly onto the shield allowing the baby to take as much of the areola as possible.~~
~~2. Allow baby to breastfeed on one breast as long s/he likes.~~
~~a. Repeat on the other breast if baby shows a desire to continue breastfeeding.~~

~~**Cleaning and Care:**~~

~~1. Wash Nipple Shield in hot soapy water. Rinse well. Dry on clean paper towel.~~
~~2. Store with the nipple facing upward and keep in a clean and dry covered container.~~

~~**Reportable conditions/Referral to Lactation Consultant:**~~

~~1. Continued inability to sustain latch.~~
~~2. Absence of audible swallow after several minutes of sucking.~~

Department Review	Department of Pediatrics	~~Division~~ Department of OB/GYN	Perinatal Collaborative Practice	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Administration	Board of Directors
07/03, 06/06, 07/09, 01/18	02/18	08/09,12/09, 04/10	n/a	n/a	07/18	n/a	08/18	06/06, 04/10

3. Decrease from initial birth weight of > 7%.

Signs of dehydration or anemia.If a patient is still using a breastfeeding aid (nipple shield or SNS) at the time of discharge, the patient shall be referred to Lactation services to schedule a follow-up appointment in the outpatient clinic within a few days of discharge.

b. Patient will coordinate date and time of outpatient visit with lactation team prior to discharge

c. Note: it is not uncommon for a mother to use a breast feeding aid for 2 weeks to 6 months to aid the transfer of milk to the neonate, for the following conditions:

i. Nipple abnormalities (e.g., flat, inverted, fibrous).

ii. Premature infant.

Application of a Supplemental Nursing System:

1. 1. Assemble tubing with syringe or container ("Starter SNS").
   a. Considered a single-use piece of equipment.
2. Gently tape tubing to mother's breast with the end of the tubing extending about ¼ inch beyond the end of nipple.
2. Assist mom to encourage her infant to latch on to breast and tubing.
   a. Sucking from the infant creates a siphon effect and allows supplementation from the reservoir of the syringe or SNS container kit
3. Supplementation should be monitored accordingly.
   a. Amounts of expressed breast milk or formula should be measured to meet infant's needs.
   b. 10-15 mL of breast milk or formula is considered adequate intake for the newborn infant without overfeeding. This will support cue-based feeding to help the infant regulate his/her feeding schedule.

REFERENCES:

1. AAP, Wight, N.E. (2008). Best Medicine: "Human Milk in the NICU": Hale Publishing, L.P.
2. Hoag-Nann, M. (2009). Lactation Management: "Techniques, Tips, and Tools for the Health Care Provider":Serif- Buffalo, NY.
3. La Leche League International. (2006) "The Breastfeeding Answer Book: Latch on problems".
4. Manufacturer's Guidelines (2009): Medela Inc. "Nipple Shield Usage, Cleaning and Care" pamphlet.
5. WCS/NICU Policy # 6385-200: "LACTATION SERVICES".

Community Healthcare & Alliance Committee (No meeting held in August, 2018)

Tri-City Medical Center
Finance, Operations and Planning Committee Minutes
August 21, 2018

Members Present	Director Julie Nygaard, Director Larry Schallock, Dr. Gene Ma, Dr. Mark Yamanaka, Wayne Lingenfelter, Jack Cumming, Dr. Jeffrey Ferber (*joined the meeting at 12:45 pm)*
Non-Voting Members Present:	Steve Dietlin, CEO, Ray Rivas, CFO, Scott Livingstone, COO, Sharon Schultz, CNE, Susan Bond, General Counsel
Others:	Jane Dunmeyer, Tom Moore, Glen Newhart, Eva England, Candice Parras, Jeremy Raimo, Sherry Miller, Mark Albright, Maria Carapia, Colleen Thompson, Dr. Scott Worman, Chris Miechowski, Barbara Hainsworth
Members Absent:	Director Cyril Kellett, Director Leigh Anne Grass, Dr. Marcus Contardo, Carlos Cruz, CCO

Topic	Discussions, Conclusions Recommendations	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to order	Director Nygaard called the meeting to order at 12:33 pm.		
2. Approval of Agenda		**MOTION** **It was moved by Director Schallock, Dr. Yamanaka seconded, and it was unanimously approved to accept the agenda of August 21, 2018.** **Members:** **AYES: Nygaard, Schallock, Ma, Yamanaka, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Kellett, Grass, Contardo, Ferber**	
3. Comments by members of the public on any item of interest to the public before committee's consideration of the item.	Director Nygaard read the paragraph regarding comments from members of the public.		Director Nygaard
4. Ratification of minutes of June 19, 2018	Minutes were ratified.	Minutes were ratified. **MOTION** **It was moved by Mr. Lingenfelter, Dr.**	

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
		Yamanaka seconded, that the minutes of June 19, 2018 are unanimously approved, with Director Schallock abstaining.	
5. Old Business	None		
6. New Business	None		
7. Consideration of Consent Calendar:	Mr. Lingenfelter requested that the following item be pulled for discussion: • 7.d. Affiliation Agreement - The Regents of The University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-City Healthcare District.	**MOTION** **It was moved by Director Schallock to approve the Consent Calendar, Mr. Cumming seconded.** **Members:** **AYES: Nygaard, Schallock, Ma, Yamanaka, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Kellett, Grass, Contardo, Ferber**	Chair
a. Premier Healthcare Solutions, Inc.		**Approved via Consent Calendar**	Thomas Moore
b. Physician Agreement for ED On-Call Coverage - Ophthalmology • Dr. Jean Paul Abboud		**Approved via Consent Calendar**	Sherry Miller
c. Physician Agreement for ED On-Call Coverage – General Surgery		**Approved via Consent Calendar**	Sherry Miller / Scott Livingstone
d. Affiliation Agreement • The Regents of The University of California, Team Physicians of Southern California Medical Group, Inc.	Sharon Schultz gave a brief overview of this collaborative physician residency education and training program. Dr. Ma, as an ED physician, offered praise for this highly regarded physician rotation program.	**MOTION** **It was moved by Director Schallock, seconded by Mr. Lingenfelter to authorize the agreement with The Regents of the University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-**	Susan Hadley / Sharon Schultz

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
& Tri-City Healthcare District		**City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 for an annual and total term cost of $104,689.56.** **Members:** **AYES: Nygaard, Schallock, Ma, Yamanaka, Lingenfelter, Cumming** **NOES: None** **ABSTAIN: None** **ABSENT: Kellett, Grass, Contardo, Ferber**	
8. Financials:	Ray Rivas presented the financials ending July 31, 2018 (dollars in thousands) **TCHD – Financial Summary** **Current Month** Operating Revenue $ 29,146 Operating Expense $ 30,126 EBITDA $ 796 EROE $ (478) **TCMC – Key Indicators** **Current Month** Avg. Daily Census 160 Adjusted Patient Days 8,876 Surgery Cases 520 Deliveries 186 ED Visits 4,975 **TCMC - Net Patient A/R & Days in Net A/R By Fiscal Year** Net Patient A/R Avg. (in millions) $ 43.6 Days in Net A/R Avg. 44.9		Ray Rivas

Topic	Discussions, Conclusio Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
	Graphs: • TCMC-Net Days in Patient Accounts Receivable • TCMC-Average Daily Census, Total Hospital-Excluding Newborns • TCMC-Acute Average Length of Stay		
9. Work Plan:			
a. Wellness Center *(bi-monthly)*	Scott Livingstone gave a brief verbal report for the Wellness Center. He conveyed that there had been no discernable changes since the last update. He further conveyed that they are currently focusing on assessing and improving the medically integrated programs.		Scott Livingstone
b. Construction Report *(quarterly)*	Chris Miechowski gave a short overview of the Construction Report. Brief discussion ensued		Chris Miechowski
c. ED Throughput *(quarterly)*	Candice Parras provided a brief update of the ED Throughput status. She conveyed that they are currently re-evaluating a change in patient volume and peak hours. Volumes have decreased by approximately 1,000 patients per month, and peak times have moved to later in the afternoon. She also emphasized some changes that have been implemented: • PA's providing medical screening exams (MSE's) on all patients presenting to Triage from 8:00 am – 2:00 am.		Candice Parras

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
	• MD Triage hours are now 10:00 am – 2:00 am • Extending provider hours in Triage has increased flow, and permitted a greater number of patients to be seen. • Improved patient satisfaction due to immediate contact with a provider, and all patients being registered at Triage.		
d. IT Physician Liaison *(semi-annual)*	Dr. Scott Worman gave a brief PowerPoint presentation detailing the following. Projects completed since January 2018: • Optimization of physician workflow for ED, Hospitalists, Cardiology and Surgery • Dragon Cloud Enterprise implementation Ongoing Projects: • Exploring options when Cerner contract ends in March 2020 • Assessment of security and health of network, prior to Cerner contract end • Enterprise storage, back-up and recovery project, including PACS system Strategic Priorities: • Full utilization of IT potential with additional Cerner applications • Infrastructure upgrade.		Mark Albright

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
e. Crisis Stabilization Unit (CSU) *(bi-monthly)*	Update postponed.		Sharon Schultz
f. Institute Updates: • Cardiovascular Institute	Eva England gave a verbal presentation on the performance and future plans for the Cardiovascular Health Institute: • $75K savings on pacemaker & defibrillator implants (Abbott / St. Jude Dual Vendor Contract) • Reduction to less than 18-days from 42-days for ST-Segment Elevation Myocardial Infarction EMI Bypass • Increase of 14 cases for Percutaneous coronary intervention • 7% increase from budget in Cath Lab volume, up 9% from FY 16-17 • Enhancement of Cardiac Rehab program with addition of peripheral artery disease (PAD) patients to program		Jeremy Raimo
• Neuroscience Institute • Orthopaedic Institute	Jeremy Raimo explained there are plans to sunset both the Neuroscience and Orthopaedic Institutes, and he requested that these items be removed from future Work Plans.	**MOTION** **It was moved by Director Schallock, Mr. Lingenfelter seconded, and it was unanimously approved to remove the Neuroscience and Orthopaedic Institutes from the Work Plan.** **Barbara Hainsworth to edit the Work Plan to reflect this change.**	
g. Dashboard	No discussion		Ray Rivas
10. Comments by committee members			

Topic	Discussions, Conclusic Recommendations	Action Recommendations/ Conclusions	rson(s) Responsible
11. Date of next meeting	Tuesday, September 18, 2018		Chair
12. Community Openings (0)			
13. Adjournment	Meeting adjourned 1:18 p.m.		

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2018
Premier Healthcare Solutions, Inc. Proposal

Type of Agreement		Medical Directors		Panel		Other:
Status of Agreement		New Agreement	X	Renewal – New Rates *(reduction)*		Renewal – Same Rates

Vendor's Name: Premier Healthcare Solutions, Inc.

Area of Service: Supply Chain Management

Term of Agreement: 36 months, Beginning, September 1, 2018 – Ending, August 31, 2021

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$14,312	$171,745	$515,236

Description of Services/Supplies:

- Subscription services to Supply chain Management's Materials Management Information System (MMIS)
- This is the main system that is used by Supply Chain Management to automate and generate all of the District's purchase orders, electronic orders, maintain supply inventories, account for supply charges to departments and patients, maintain contract pricing and also manage all of receiving functions.
- This system has been in effect at TCHD since 2006 and houses all of TCHD's purchase order history
- This renewal is a $4,000 a month discount from current pricing. $144K savings for the term.

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

Person responsible for oversight of agreement: Thomas Moore, Director, Supply Chain Management / Ray Rivas, Chief Financial Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with Premier Healthcare Solutions, Inc. for subscription services to Supply Chain Management's Materials Management Information System for a term of 36 months, beginning September 1, 2018, and ending August 31, 2021 for an average annual cost of $171,745, and a total cost for the term of $515,236.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Jean Paul Abboud, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 12 months, Beginning, September 1, 2018 – Ending, August 31, 2019

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

Maximum Totals: For entire Current ED On-Call Area of Service Coverage: Ophthalmology
No increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$300	365	$109,500
	Total Term Cost:	**$109,500**

Position Responsibilities:

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

Document Submitted to Legal for Review:	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: Sherry Miller, Manager, Medical Staff / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors add Jean Paul Abboud, M.D. to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 12 months, beginning September 1, 2018 and ending August 31, 2019.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2018
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – General Surgery

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

Physician's Name: Andrew Deemer, M.D.; Adam Fierer, M.D.; Dhruvil Gandhi, M.D.; Karen Hanna, M.D.; Eric Rypins, M.D.; Katayoun Toosie, M.D.; Mohammad Jamshidi-Nezhad, D.O.;

Area of Service: Emergency Department On-Call: General Surgery
Term of Agreement: 12 months, Beginning, August 1, 2018 – Ending, July 31, 2019
Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: General Surgery

Rate/Day	Panel Days per Year	Panel Annual Cost
Mon-Sunday $1,400	FY19: 365 days	$511,000
	Total Term Cost:	**$511,000**

Unfunded Cholecystectomy Cost	Estimated Cases per Year	Estimated Annual Cost
$725, per case	FY19: 36	$26,100
Unfunded Laparoscopic Cholecystectomy with Common Bile Duct Exploration	**Estimated Cases per Year**	**Estimated Annual Cost**
Procedure Code 47564: $1,144.51, per case	FY19: 5	$5,722.55
Procedure Code 47550: $168.05, per case	FY19: 5	$840.25
	Total Term Cost:	**$32,662.80**

Position Responsibilities:

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

Document Submitted to Legal:	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: Sherry Miller, Manager, Medical Staff Services / Scott Livingstone, Chief Operating Officer

Motion: I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize ...eons, Andrew Deemer, M.D.; Adam Fierer, M.D.; Dhruvil Gandhi, M.D.; Karen Hanna, M.D.; Eric Rypins, M.D.; Katayoun ...osie, M.D.; Mohammad Jamshidi-Nezhad, D.O. , as the General Surgery ED-Call Coverage Physicians for a term of 12 months, beginning August 1, 2018 and ending July 31, 2019 at a daily rate of $1,400, for an annual and term cost of $511,700. Reimbursement of $725 per case for Unfunded Cholecystectomy and Unfunded Laparoscopic Cholecystectomy with Common Bile Duct Exploration (code 47564: $1,144.51 / case and code 47550: $168.05) at an expected total cost for these unfunded cases for the term of $32,662.80.

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: August 21, 2018
AFFILIATION AGREEMENT

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

Vendor's Name: The Regents of The University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-City Healthcare District

Area of Service: Education

Term of Agreement: 12 months, Beginning, July 1, 2018 – Ending, June 30, 2019

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$8,724.13	$104,689.56	$104,689.56

Description of Services/Supplies:

- Emergency Residency Program – Providing Education and Training Programs to Trainees.

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

Person responsible for oversight of agreement: Susan Hadley, Director, Network Development / Steve Dietlin, Chief Executive Officer

Motion:
I move that Finance Operations and Planning Committee recommend that TCHD Board of Directors authorize the agreement with The Regents of the University of California, Team Physicians of Southern California Medical Group, Inc. & Tri-City Healthcare District for an Emergency Residency Program to provide education and training to trainees, for a term of 12 months, beginning July 1, 2018 and ending June 30, 2019 for an annual and total term cost of $104,689.56.

Professional Affairs Committee
(No meeting held in August, 2018)

Audit, Compliance & Ethics Committee
(No meeting held in August, 2018)

Tri-City Medical Center
Audit, Compliance & Ethics Committee
July 26, 2018
Assembly Room 1
8:30 a.m-10:30 a. m.

Members Present:	Director Larry W. Schallock(Chair); Director James Dagostino; Director Julie Nygaard; Kathryn Fitzwilliam, Community Member; Leslie Schwartz, Community Member; Faith Devine, Community Member
Non-Voting Members:	Steve Dietlin (CEO); Scott Livingstone, COO; Ray Rivas, CFO; Carlos Cruz, CCO
Others Present:,	Teri Donnellan, Executive Assistant; Kristy Larkin, Director of Compliance, Audit & Monitoring; Maria Carapia, Contract Analyst – Compliance Manager; Jane Dunmeyer, League of Women Voters; Stacy Stelzriede, Engagement Partner (Moss Adams); Annie Norviel, Audit Senior Manager (Moss Adams)
Absent:	Cary Mells, M.D.; Physician Member; Susan Bond, General Counsel

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
1. Call to Order	The meeting was called to order at 8:30 a.m. in Assembly Room 1 at Tri-City Medical Center by Chairman Schallock.		
2. Approval of Agenda	**It was moved by Director Dagostino and seconded by Director Nygaard to approve the agenda as presented. The motion passed unanimously.**	**Agenda approved.**	
3. Comments by members of the public and committee members on any item of interest to the public before Committee's consideration of the item	There were no public comments.		
4. Ratification of minutes – April 14, 2018	**It was moved by Director Nygaard and seconded by Director Dagostino to approve the minutes of April 14, 2018, as presented. The motion passed unanimously.**	**Minutes ratified.**	
5. Old Business	None		
6. New Business	Mr. Ray Rivas introduced Stacey Stelzriede, Engagement Partner and Annie Norviel, Audit Senior Manager.	**Information only.**	

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
a) Fiscal 2018 Financial Statement Audit Entrance – Moss Adams	Ms. Stelzriede stated the Moss Adams audit team for Tri-City consists of herself, Annie Norviel and Brian Conner, Concurring Reviewer and Matt Parsons, Audit Senior Manager (Single Audit). Ms. Stelzriede and Ms. Norviel presented information on the following: ➢ Required Communications to those Charged with Governance ➢ Our Responsibility Under US Generally Accepted Auditing Standards and Government Auditing Standards ➢ Audit Process • Internal Controls • Analytical Procedures • Substantive Procedures ➢ What is Materiality? ➢ Significant Audit Areas • Patient Revenue/Receivables • Cost Report Settlements • Self-Insurance Liabilities • Line of Credit and Long-Term Debt (HUD Financing, covenant compliance and Single Audit) • MOB Legal Proceedings ➢ Consideration of Fraud ➢ Deliverables ➢ Audit TimeLine Ms. Stelzriede explained the Auditor's role is to plan and perform the audit in accordance with generally accepted auditing standards and to design the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. Ms. Stelzriede emphasized that the audit of the financial statements does not relieve the Board or management of their responsibilities.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Ms. Norviel explained how the auditors will gather information to identify fraud-related risks of material misstatement and the procedures to be performed which will include but not be limited to testing and analyzing significant accounting estimates or biases. Ms. Norviel stated interim work on the Audit began in May where the first step was to test internal controls and make sure they are effective. Analytical procedures were also done in which they looked at historical data, ratios and Substantive Procedures. Ms. Norviel stated the audit team will be on site in August to go through the next steps of the audit. Ms. Stelzriede explained that Materiality is the amount of misstatement that could influence the economic decisions of users, taken on the basis of the consolidated statements. She stated the auditors do their own estimates and see if they agree with managements. Ms. Stelzriede also explained that auditors are required to design their audit to detect fraud. They also focus on security and access. Ms. Norviel explained the Deliverables which include an audit report on the financial statement of Tri-City Healthcare District as of and for the year ended June 30, 2018. With regard to the Single Audit (HUD) they will issue a GAGAS Report on Internal Control over Financial Reporting and on Compliance and Other Matters and a report on Compliance for each Major Program and Report on Internal Control over Compliance Required by Uniform Guidance. With regard to timing of the audit, Ms. Stelzriede stated she expects to present the audit results to the committee and the Board at their September meetings Ms. Stelzriede also provided an update of New Standards which included GASB 84 – Fiduciary Activities, GASB 85 – Omnibus 2017, GASB 86 – Certain Debt Extinguishment Issues, GASB 87 – Leases, GASB 88 – Certain disclosures		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
	Related to Debt, and proposed changes for the Data Collection Form that will be effective for 2019. Lastly, Ms. Stelzriede commented on the 2018 Health Care Conference entitled Disruption/Innovation/Transformation which is scheduled on November 15-16, 2018 and which is often attended by C-Suite Executive Teams and Board members to share industry knowledge, best practices and new ideas. Committee members asked questions of the auditors throughout the presentation. *Ms. Stelzriede and Ms. Norviel left the meeting at 9:11a.m.*		
b) Administrative Policies & Procedures: 1) 8610-262 – Ethics in Provision of Services 2) 8610-596 – Identity Theft (Red Flag Rules)	Mr. Carlos Cruz stated amendments to Policy 8610-262 were made for clarification. Committee members did not have any questions. Minor revisions were requested to Policy 8610-596 for clarification. **It was moved by Director Dagostino to recommend approval of Policy 8610-262 as written and 8610-596 with amendments as described.**	**Recommendation to be sent to the Board of Directors to approve Policy 8610-262 – Ethics in Provision of Services and 8610-596; item to be placed on Board agenda and included in Board packet.** **Recommendation to be sent to the Board of Directors to approve Policy 8610-596 – Identity Theft (Red Flag Rules) following amendments as described.**	Ms. Donnellan
7. Motion to go into Closed Session	**It was moved by Ms. Fitzwilliam and seconded by Director Dagostino to go into closed session a 9:12 a.m. The motion passed unanimously.**		
11. Open Session	The committee returned to open session at 10:00 a.m. with attendance as previously noted.		

	Discussion	Action Recommendations/ Conclusions	Person(s) Responsible
12. Report from Chairperson on an any action taken in Closed Session (Authority: Government Code, Section 54957.1)	Chairperson Schallock reported no action was taken in closed session.		
13. Comments from Committee Members	There were no comments from members of the committee.		
14. Committee Openings	There are no committee openings.	**None**	
15. Date of Next Meeting	The Committee's next meeting is scheduled for September 20, 2018.		
16. Adjournment	Chairman Schallock adjourned the meeting at 10:01 a.m.		

AUDIT COMPLIANCE AND ETHICS COMMITTEE CONSENT AGENDA ADDENDUM
July 26, 2018

Administrative Policies & Procedures	Policy #	Reason	Recommendations
1. Identity Theft (Red Flag Rules)	596	3 year review, practice change	Forward To BOD For Approval

Tri-City Health Care District
Oceanside, California

Administrative Policy ~~Manual~~
Compliance

ISSUE DATE: 12/08 **SUBJECT: Identity Theft (Red Flag Rules)**

REVISION DATE(S): **POLICY NUMBER:** 8610-~~531~~596

Department Approval:	**01/18**
Administrative Policies & Procedures Committee Approval:	**~~10/08~~01/18**
~~Operations Team Committee Approval:~~	**~~10/08~~**
Medical Executive Committee Approval:	**02/18**
Organizational Compliance Committee Approval:	**04/18**
Audit, Compliance and Ethics Committee Approval:	**07/18**
~~Professional Affairs Committee Approval:~~	**~~11/08~~**
Board of Directors Approval:	**12/08**

A. **PURPOSE:**

1. **To develop an Identity Theft Prevention Program that protects patients by reducing the risk of identity theft by establishing requirements for identifying, investigating and responding to identity theft red flags.~~To protect our patients, reduce risk from identity fraud, and minimize potential damage from fraudulent activities. TCMC is subject to 16 CFR 68.12 "Identify Theft Rules" which requires the hospital to establish an Identify Theft Prevention Program.~~**

B. **POLICY:**

1. **Tri-City Healthcare District (TCHD) is subject to Identity Theft Rules, 16 C.F.R. §~~section~~ 681, which requires ~~Tri-City Medical Center (TCMC~~HD~~)~~ to establish an Identity Theft Prevention Program (ITPP).~~Tri-City Medical Center is committed to the prevention of identity theft by strictly adhering to the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.~~ TCHD maintains and administers an ITPP to detect, prevent and mitigate identity theft in connection with new or existing patient accounts.**

~~B.~~2. **TC~~MC~~HD collects registration and billing information to create patient accounts and/or bill for the provision of healthcare services. Patient accounts are a specific subset of covered accounts.** ~~Tri-City Medical Center~~**TC~~MC~~HD** will address the issues of identity theft including:

   a. Identifying potential red flags that signal identity theft.
   b. Training appropriate staff to recognize and mitigate red flags.
   c. Notifying individuals and local law enforcement if personal information may have been compromised.
   d. Review red flag process routinely to protect against any changes in risk.

C. **DEFINITIONS:**

1. Red Flag: **A pattern, practice, or specific activity that indicates the possible existence of identity theft.** Warning signs of identity theft include but not limited to address discrepancy, name discrepancy, suspicious documents, conflicting personal information, and notice from patients or law enforcement.

~~2.~~**D. PROCEDURE:**

1. ~~1.~~Verify identification of patient.
   a. Patient's identity should be verified with government issued photo identification **(ID).** ~~Acceptable If the patient refuses or is unable to provide a photo ID~~

i. **Acceptable** government documentation **includes**:
   1) Passport
   2) Driver's license or equivalent
   3) Military ID
   4) Permanent resident card.

b. **Upon initial registration, adult patients should be asked to show documentation of identity that includes address information, with the following exceptions:**
   i. **If the patient requests emergency evaluation or treatment, TCMCHD will not delay a medical screening examination in order to obtain documents verifying identity.**
   ii. **TCMCHD staff may use professional judgment to waive the production of photo ID if a delay in care could put the patient's health and safety at risk.**

~~A.~~c. **When reviewing a patient's ID, TCMCHD should do the following:**~~S~~
   ~~B.~~i. Scrutinize to verify that it has not been altered or forged.
   ~~C.~~ii. Verify that the picture and physical description on the identification provided matches the appearance of the patient.
   ~~3.~~iii. Verify that the information on the identification is consistent with the information in the patient Medical Record.

~~D.~~d. **If a patient refuses or is unable to provide a photo ID, TCMCHD staff should document that photo ID was "not provided". In addition, the TCMCHD staff member should ask the patient for two (2) forms of non-photo ID, one of which has been issued by a state or federal agency (i.e., ~~Social Security~~Medicare ID card or number,~~and~~ utility bill or company or school ID). When the patient is under 18 or if the patient is unable due to their condition to produce ID, the responsible party's ID shall be requested**

~~1.~~2. Red Flags
   a. Everyone shall be alert to potential red flags.
   b. Below are examples of red flags to look for:
      ~~E.~~i. -Complaints or concerns from a patient relating to:
         1) Received a bill for someone else.
         2) Received a bill for services that were not received.
         3) Received information from Insurance Company for services that were not received.
         4) Collection notice for services never received.
      ~~F.~~ii. -The photograph on the identification does not resemble the patient.
      ~~G.~~iii. Identifying information given by the patient is not consistent with the patients' medical record.
      ~~H.~~iv. Social Security Number Red Flags:
         ~~i.~~1) ~~1)~~The social security number has not been issued.
         ~~I.~~2) The social security number is listed in Administration's Death Master File
         ~~J.~~3) The social security number is invalid.
         ~~K.~~4) The following numbers are always invalid:
            a) The first three digits are in the **following ranges:**
               (i) 000
               (ii) Above 772
               (iii) 800
               ~~a)~~**(iv) 900**~~800, 900, or 000 are in the 700 range above 772 or are 666~~.
            b) The fourth and fifth digits are 00.
            c) The last four digits are 0000.
            ~~b.~~d) ~~E.~~The identifying information furnished by the patient including the Social Security Number are the same as another patient.
      ~~c.~~v. ~~F.~~Other Red Flags:

1) The address given by the patient does not exist or is a post office box.
2) The phone number given is invalid, or is associated with a business, disconnected etc.
~~ii.~~3) ~~3)~~ The patient fails to provide identifying information after repeated tries.
~~L.~~4) The information provided by the patient differs from the informant in the medical record or is different on clinical examination.
~~M.~~5) The patient's signature does not match the signature in the medical record.
~~N.~~6) Notification from patient stating they are a victim of identity theft.
~~O.~~7) The entity received notice of address discrepancy from a consumer reporting agency.
8) Discrepancies in information provided by patient in the medical record.

~~P.~~3. **Investigations:**

a. **TCHD shall investigate concerns involving potential identity theft associated with patient accounts.**

~~1.~~b. **If it is determined that a patient is a victim of identity theft, the following actions shall be taken:**

~~a.~~i. **Promptly isolate and correct any inaccuracy in the patient's designated record set.~~;~~**

~~b.~~ii. **Notify the patient in writing or by phone.~~;~~**

~~c.~~iii. **Instruct billing areas to cease collection; if the account has been referred to a collection agency, instruct the collection agency to cease collection activity.~~;~~**

~~d.~~iv. **Cooperate with any law enforcement investigation.~~;~~**

~~e.~~v. **Ascertain whether an insurance company, government program, patient or other payeer has made payment on the account, notify the payeer of the incident and arrange for a refund of the amount paid.~~;~~**

~~f.~~vi. **~~-~~If an adverse report was made to a consumer reporting agency, notify the agency of the incident and explain that the account was not the responsibility of the patient~~; and~~.**

vii. **Notify all other TCHD departments as necessary to resolve and/or restore the accuracy of account information.**

4. **Remediation:**

a. **When identity theft is confirmed, any documents identified as not belonging to the patient shall be segregated and any information relating to the identity theft shall be removed, marked in error or suppressed (as applicable to whether paper documents or electronic systems are affected).**

5. **Address Discrepancy**

a. **When TC~~M~~CHD receives a notice of address discrepancy from a consumer reporting agency, TC~~M~~CHD shall verify that the report relates to a patient about whom the information is requested.**

~~2.~~6. **~~TCHD~~Administrative Policy: 8610-395~~,~~ Fraud Recognition ~~and~~ Response, details all measures taken by TCHD when identity theft has been identified.**

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

~~3.~~1. **Administrative Policy: 395 Fraud Recognition Response**
2. **Patient Care Services Procedure: Medical Record, Making Corrections to Documentation**

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

1. ~~16 CFR 68.12 "~~Identify Theft Rules~~"~~, **CFR Title 16 Div. § 681.**
2. Federal Register Vol. 72, No. 217~~,~~ ~~November 9,~~ (2007).
3. **Federal Trade Commission (2008). New 'red flag' requirements for financial institutions and creditors will help fight identity theft. FTC** Business Alert~~, June 2008~~.

~~3.~~4. **Identity Theft Rules: Interim Final Rule and Request for Comment - Amendment of the Definition of "Creditor" in the Original Red Flags Rule, CFR Title 16 § 681 (2012).**

5. **Red Flag Program Clarification Act of 2010, 15 U.S.C. 1681m(e)(4), Pub. L. 111-319, 124 Stat. 3457 (2010).**

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

July 26, 2018 – 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 July 26, 2018.

The following Directors constituting a quorum of the Board of Directors were present:

Director James Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, MD
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Dr. Victor Souza, 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

Chairman Dagostino requested the following modifications to the agenda:

1) Strike two matters of Potential Litigation;
2) Add one matter of Potential Litigation;
3) Strike all Closed Session minutes;
4) Strike the Educational Session;
5) Add two matters of New Business related to the addition of Dr. Anitha Rajamanickam to the ED Call Panel for Cardiology and Stemi
6) Strike Policy 8610-596 - Identity Theft (Red Flag Rules)

It was moved by Director Schallock to approve the agenda as amended. Director Mitchell seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

Chairman Dagostino read the Public Comments section listed on the July 26, 2018 Regular Board of Directors Meeting Agenda.

There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

Chairman Dagostino made an oral announcement of the items listed on the July 26, 2018 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees; and Conference with Legal Counsel regarding five (5) matters of Potential Litigation.

5. Motion to go into Closed Session

It was moved by Director Kellett and seconded by Director Nygaard to go into Closed Session. The motion passed unanimously (7-0).

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 Dagostino, DPT, PT
Director Leigh Anne Grass
Director Cyril F. Kellett, M.D.
Director Laura E. Mitchell
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Also present were:

Colin Coffey, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairman Dagostino reported no action was taken in closed session.

10. Chairman 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 24. Chairman Dagostino requested that speakers adhere to the three minute time allotment.

12. Educational Session:

a) Board Fiduciary Duties Related to the Employee Pension Plan

The Educational Session was pulled from the agenda and deferred to a future meeting.

13. Report from TCHD Foundation – Glen Newhart, Chief Development Officer

Mr. Glen Newhart, Chief Development Officer provided a brief report on some of the items the Foundation has funded this past year including the following:

- 3D Tomo
- Breast Feeding Education
- Cancer Navigator
- Cancer Screenings
- Cardiac Rehab
- Cardiology
- Hospice Comfort Care
- ICU/Labor & Delivery/NICU/Pre-op/Pulmonary Rehab
- Smoking Cessation Classes
- Socks & Shoes for Patients in Need
- SonoCine

Mr. Newhart stated as we start this new fiscal year the Foundation will focus on supporting the award winning heart and stroke programs here at Tri-City and the funds raised through the Golf Tournament and Diamond Ball will all be allocated towards our Cardiovascular programs.

Mr. Newhart reported Rita Geldert is the Foundation's new Board Chair. Dr. David Tweedy is the Foundation's immediate past Chair. On behalf of the entire Foundation, Mr. Newhart expressed his appreciation to Dr. Tweedy for his two yeas of service.

Mr. Newhart stated the Foundation is working on the September issue of *For Good* newsletter which will include stories from patients battling Parkinson's and the programs that are being offered through the Wellness Center for these patients.

Mr. Newhart report the Diamond Ball is coming up in October. He expressed his appreciation to the Diamond Ball Committee volunteers who are helping plan the event.

Lastly, Mr. Newhart reported Senator Pat Bates spent an hour with the Foundation Board members, employees and Auxilians to celebrate the award the Foundation received for the California Non-Profit of the Year. Mr. Newhart emphasized that Tri-City Hospital Foundation was the only Hospital Foundation to win a non-profit of the year this year. Mr. Newhart stated Senator Bates was extremely gracious with her time and seemed to have a genuine affection for Tri-City.

No action taken.

14. Report from Chief Executive Officer CEO

Mr. Steve Dietlin provided a brief report in which he recognized the Foundation for the California Non-Profit of the Year Award and the American Heart Association awards for Clinical Excellence. He also spoke at length regarding the challenging healthcare regulatory and reimbursement environment. He stressed the need to remain proactive and flexible while at the same time maintaining the highest standards in order to preserve the future for healthcare delivery in this community.

Mr. Dietlin also discussed the updated federal regulatory standards requiring substantial environment of care structural modifications for mental health patients in aged hospital settings. He emphasized the importance of patients being in the safest possible environment of care setting and the estimated timeframe it would take to perform required modifications along with the estimated cost of well over $6 million. He explained that the structural cost is only one component. Regardless of the cost of structural modifications, a one year timeframe or more is not appropriate or acceptable to reach updated environment of care safety standards. He stated patient safety must be the foremost on our minds. Therefore action was taken to suspend Inpatient Behavioral Health Unit and Crisis Stabilization Unit operations in an expedited and orderly manner while maintaining the highest possible patient safety. Mr. Dietlin stated these actions taken to suspend operations are difficult but necessary and were supported unanimously by the Board of Directors, the Administration and members of the Medical Staff. Mr. Dietlin stated Tri-City remains committed to working with our public and private partners and other community leaders for long term sustainable solutions.

No action taken.

15. Report from Chief Financial Officer

Mr. Ray Rivas reported due to the impending audit, Finance keeps the books open to the very last minute to make sure we have captured everything and avoid any possible audit adjustments.

Mr. Rivas gave a brief report on the Audit Entrance report that was given to the Audit, Compliance & Ethics Committee at this morning's meeting by Moss Adams. The report included the scope and timing of the audit and the audit process. Mr. Rivas noted a single audit is also required due to the HUD financing. The auditors anticipate bringing forward the audit for acceptance by the Board at the September regular board meeting.

No action taken.

16. Report from Chief Governmental & External Affairs Officer

Ms. Aaron Byzak, Chief Government External Affairs Officer provided a report on the development of a comprehensive legislative reform agenda focused on mental health. He also provided a recap of a related matter by the County Board of Supervisors related to an assessment of inpatient Behavioral Health beds in the county.

Chairman Dagostino expressed his appreciation to Mr. Byzak for his efforts.

No action taken.

17. New Business

a) Consideration to cast the ballot on behalf of the District in CSDA's 2018 Board of Director's election for Seat A in Southern Network

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors authorize the Board's Executive Assistant to cast the ballot in favor of Joe McKenzie in CSDA's 2018 Board of Director's election for Seat A. Director Reno seconded the motion.

Director Nygaard stated she has worked with Ms. McKenzie in the past and believes she is well qualified for the position. Director Reno echoed Director Nygaard's comments.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b) Consideration to authorize Dr. Anitha Rajamanickam to join the existing group as the Cardiology-General ED Call coverage physician.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve Dr. Anitha Rajamanickam to join the existing group as the Cardiology-General ED Call coverage physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily rate of $300 and an annual and term cot of $109,500. Director Nygaard seconded the motion.

Director Nygaard explained that Dr. Rajamanickam is simply joining an existing ED Call Group for both General Cardiology and STEMI.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c) Consideration to authorize Dr. Anitha Rajamanickam to join the exiting group as the Cardiology-STEMI ED Call coverage physician.

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve Dr. Anitha Rajamanickam to join the existing group as the Cardiology-STEMI ED Call coverage physicians for a term of 12 months, beginning July 1, 2018 through June 30, 2019, at a daily rate of $600 and an annual and term cost of $219,000. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Old Business - None

19. Chief of Staff

a. Consideration of July Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on July 23, 2018.

It was moved by Director Grass that the Tri-City Healthcare Board of Directors approve the July Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on July 23, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b) Consideration of NP Standardized Procedures:

1) Cardiology
2) Gastroenterology
3) Hospitalist
4) Interventional Radiology
5) Neonatal
6) Neurology
7) OB/GYN
8) Orthopedic & Spine Institute
9) Psychiatry Division
10) Psychiatry Division
11) Psychiatry Division/CSU

It was moved by Director Grass that the Tri-City Healthcare District Board of Directors approve the NP Standardized Procedures as presented and recommended by the Medical Executive on July 23, 2018. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**

ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

b) Consideration of Ortho Tech Privilege Card Revision

It was moved by Director Mitchell that the Tri-City Healthcare District Board of Directors approve the Ortho Tech Privilege Card Revision as presented and recommended by the Medical Executive on July 23, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Reno, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

c) Consideration of Continuing Education Mission Statement

It was moved by Director Reno that the Tri-City Healthcare District Board of Directors approve the CME Mission Statement as presented and recommended by the Medical Executive on July 23, 2018. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

20. Consideration of Consent Calendar

It was moved by Director Schallock to approve the Consent Calendar. Director Kellett seconded the motion.

It was moved by Director Mitchel to pull item D. (4) a) ACHD Membership Dues. Director Nygaard seconded the motion.

The vote on the main motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

The vote on the main motion, minus the item pulled was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

21. Discussion of items pulled from Consent Agenda

Director Mitchell who pulled the ACHD Membership Dues stated she does not believe ACHD advocates on our behalf and believes Districts such as Tri-City are subsiding those Districts that do not have a hospital. Director Nygaard echoed Director Mitchell's comments. Director Reno questioned if a lower type membership is available. Director Nygaard stated the membership is a set amount. She stated Board members would still be able to attend ACHD functions but at a non-member cost.

It was moved by Director Mitchell that the Tri-City Healthcare Hospital District not renew their membership with ACHD. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

22. Reports

Director Schallock requested clarification on the Clinical Contract Evaluation statement. Ms. Bond stated the Board has received the report and contract evaluation and suggested there be a motion approving the contract evaluation.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors accept the Clinical Contract Evaluation that was presented and reviewed by the Board. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Dagostino, Grass, Kellett, Mitchell, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

24. Comments by Members of the Public

Chairman Dagostino recognized the following individuals who urged the Board to reconsider the suspension of the Behavioral Health Inpatient Unit and Crisis Stabilization Unit: David Tweedy, Liz Kruidenier, Courtney Hayes, Mike Bagby, Diane Bagby, Mali Woods, Kate Schwartz, Esther Sanchez and Larry Kornit.

25. Additional Comments by Chief Executive Officer

Mr. Dietlin had no additional comments

26. Board Communications

Reports from Board Members

Directors Schallock, Kellett, Reno, Nygaard, Grass and Mitchell had no comments.

27. Report from Chairperson

Chairman Dagostino thanked the public for their input.

31. There being no further business Chairman Dagostino adjourned the meeting at 4:45 p.m.

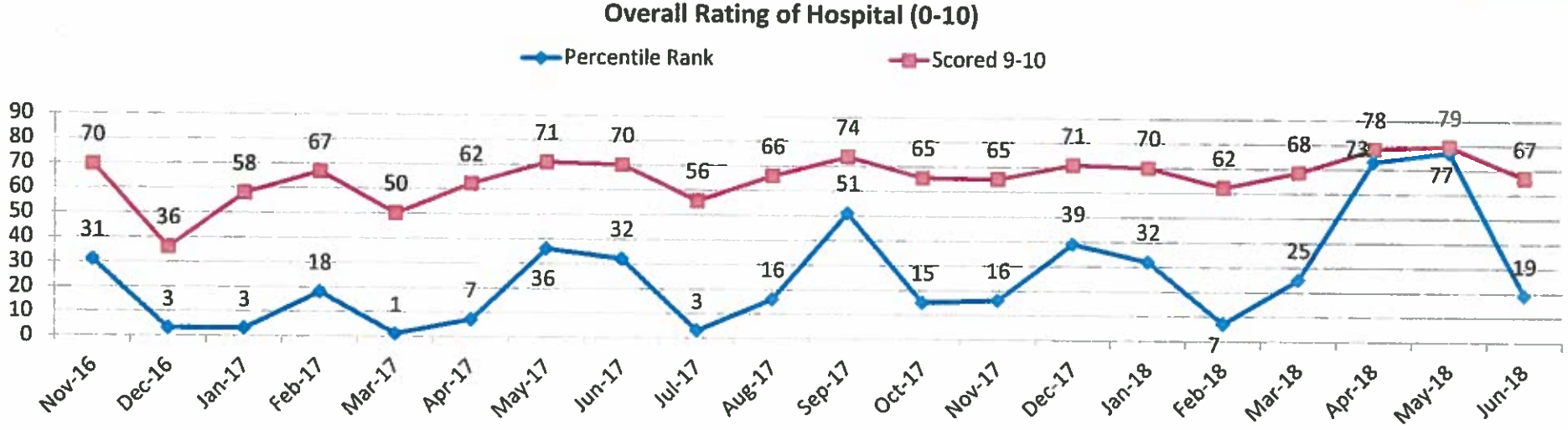
James J. Dagostino, DPT, PT
Chairman

ATTEST:

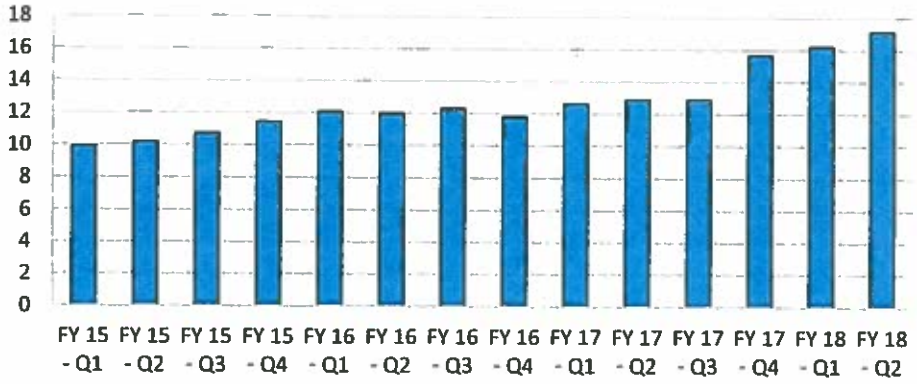
Leigh Anne Grass, Secretary

Stakeholder Experiences

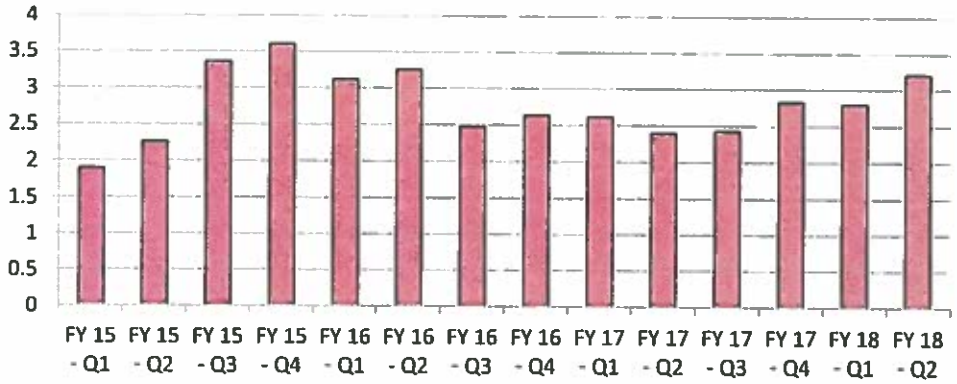
Overall Rating of Hospital (0-10)



Voluntary Employee Turnover Rate



Involuntary Employee Turnover Rate



Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	26	23	23	20	27	27	22	23	24	20	20	28	283
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	C/M YTD
FY18	14	6	7	13	7	15	14	8	12	7	10	6	119
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	C/M YTD
FY18	11	12	12	14	16	18	23	12	15	15	16	20	184
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	C/M YTD
FY18	15	20	20	16	23	15	15	19	23	11	20	17	214
FY17	18	18	17	14	20	22	20	16	18	13	17	19	212

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	48	37	33	32	26	38	29	24	30	38	33	38	406
FY17	31	35	29	42	34	29	31	30	31	37	28	41	398

Performance compared to prior year: Better Same Worse

Inpatient Behavioral Health - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	15.7	14.5	16.2	16.3	9.9	14.2	16.7	12.5	13.7	13.8	13.0	11.9	14.1
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	C/M YTD
FY18	9.0	6.7	6.2	9.5	8.3	7.3	7.2	8.7	7.5	7.1	6.6	4.8	7.4
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	6.3

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	11.3	16.4	12.4	13.9	13.5	10.5	12.5	12.7	12.4	11.5	12.2	13.5	12.7
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	14.5

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	169.7	181.9	163.4	173.4	160.9	172.5	210.7	185.8	186.4	163.2	161.9	165.9	174.7
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	181.1

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	210	222	194	206	184	166	209	169	186	156	163	188	2,253
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	C/M YTD
FY18	12	11	11	11	11	18	16	5	7	16	15	20	153
FY17	12	11	12	16	11	14	15	11	6	15	12	18	153

Performance compared to prior year: Better Same Worse

Outpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	4	7	7	3	4	3	2	4	8	2	7	8	59
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	C/M YTD
FY18	8	7	7	11	3	14	11	10	4	10	8	5	98
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	C/M YTD
FY18	1.75	1.80	1.81	1.80	1.83	1.72	1.64	1.77	1.78	1.85	1.86	1.79	1.78
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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6		48.3	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	49.5	

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	87.7	81.3	82.9	85.2	78.8	83.2	89.2		82.9	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	83.2	

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)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)		($7,380)	$3,418
FY17	$288	$211	$746	$1,118	$414	$317	($226)	$181	($2,912)	($63)	$296	$1,510	$371	

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%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%		-2.23%	1.01%
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%	0.12%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

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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	($1,288)	$908	$81	$751	$963	$571	$900		$6,885	$18,345
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	$14,305	

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%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%		2.08%	5.42%
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%	4.61%	

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	6.50	6.43	5.95	5.99	5.86	6.29	6.42		6.26	6.23
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	6.11	

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	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5		
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

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	44.9												44.9	48-52
FY18	47.7	47.8	48.9	50.8	49.6	49.5	49.8	47.2	46.8	47.0	46.6		47.7	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY19	84.9												84.9	75-100
FY18	82.1	79.1	78.8	83.4	87.7	81.3	82.9	85.2	78.8	83.2	89.2		82.1	

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
FY19	($478)												($478)	($579)
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)		($394)	

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
FY19	-1.64%												-1.64%	-2.03%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%		-1.33%	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY19	$796												$796	$726
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900		$898	

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
FY19	2.73%												2.73%	2.54%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%		3.03%	

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
FY19	6.73												6.73	6.36
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43		6.51	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY19	$50.0												
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5		

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Construction Report
As of July 2018

Project	FOP/Board Approval Date	% of Design Complete	Construction Start or Estimated Construction Start Date	Estimated Construction Completion Date*	% of Construction Complete	Total Budget	Actual Expenditures	Remaining Budget	Status / Comments
OR #4 Surgical Lights Replacement	September-17	100%	July-18	September-18	0%	$ 510,761.00	$ 127,633.54	$ 383,127.46	Scheduling construction.
Retail Pharmacy	September-17	100%	January-18	April-18	98%	$ 373,293.00	$ 324,713.85	$ 48,579.15	Awaiting State Licensing
BHU Seclusion Room	September-17	100%	January-18	August-18	80%	$ 295,482.00	$ 163,445.59	$ 132,036.41	Construction in progress.
Sonocine Room Addition	December-17	100%	January-18	June-18	100%	$ 392,582.00	$ 346,531.07	$ 46,050.93	Project Complete
Surface Parking Lot	December-17	100%	February-18	August-18	85%	$ 2,473,975.00	$ 1,255,538.39	$ 1,218,436.61	Construction in progress.
Total Construction Projects						**$ 4,046,093.00**	**$ 2,217,862.44**	**$ 1,828,230.56**	

*Estimated completion is based on actual physical project progress and not on amounts invoiced to the District

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending July 31, 2018

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	$3.59	(a)	45,637.80	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	Approx 1,558	$2.47	(a)	5,029.28	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	$1.91	(a)	10,811.19	04/01/16	01/31/20	**PCP Clinic - Radiance** 3998 Vista Way, Ste. C Oceanside, CA 92056
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	10,218	$2.58	(a)	31,646.40	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,540.00	02/01/15	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	$2.58	(a)	15,640.35	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081
Elfin Investments, LLC Clancy Medical Group 20136 Elfin Creek Trail Escondido, CA 92029 V#82575	3,140	$2.62	(a)	9,867.81	12/01/15	12/31/20	**PCP Clinic - Clancy** 2375 Melrose Dr. Vista Vista, CA 92081
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)	9,973.25	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	$4.12	(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	$1.10	(a)	5,135.39	10/28/13	10/31/18	**Vacant Building** 510 Hacienda Drive Suite 108-A Vista, CA 92081
Total				**$ 190,429.48**			

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 2018

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6010	2018 LEAD ACADEMY SESSIONS 3-6	62718	1,372.03	83176	JONATHAN DEVERA
6185	ONS ONCC CHEMOTHERAPY BIOTHERAPY	72318	279.00	12044	KATHRINE WYLIE
6185	ONS ONCC CHEMOTHERAPY BIOTHERAPY	71818	279.00	83250	CHRISTINE BWAMBOK
7400	AWHONN 2018 NATIONAL CONFERENCE	71718	424.00	83120	YAJAIRA PAREDES
7680	ACLS BLS RENEWAL	62518	240.00	83293	MONIQUE WALKER
8610	HEALTHCARE COMPLIANCE ASSOC NAT'L CONFERENCE	51418	856.00	83006	CARLOS A CRUZ
8620	NON PROFIT OF THE YEAR AWARD - TRAVEL	60618	158.56	81515	JAMES DAGOSTINO
8631	NON PROFIT OF THE YEAR EXPENSES	63018	332.68	79486	GLEN NEWHART
8631	NO COUNTY LEADERSHIP CLASS	63018	150.00	79486	GLEN NEWHART
8650	CONDUCTING LAWFUL WORKPLACE INVESTIGATIONS	61918CARBAJAL	1,575.00	83287	FRANCIS CARBAJAL
8740	SUICIDE PREVENTION	70618	189.00	78833	KELLI LAROSE
8740	SUICIDE PREVENTION	70618	189.00	79683	KAREN FERNANDEZ
8740	ADVANCE LACTATION	70618	200.00	79467	LISA BRUGNANO
8740	2018 IDEA WORLD CONVENTION FITNESS & NUTRITION	71318	200.00	82621	JANICE BACHAR
8740	CLINICAL LAB MANAGEMENT ASSOC KNOWLEDGE LAB	70618	200.00	82866	TARA EAGLE
8740	RADIOGRAPHY ALLIED HEALTHCARE	71318	1,000.00	82924	ROBERT MONTEFALCON
8740	MASTERS OF NURSING - SCIENCE	71318	1,255.00	81443	PAMELA MILLS
8740	BACHELORS PROGRAM	71318	2,000.00	81393	ROBERT FLORES
8756	2018 CALNOC CONFERENCE	72618HUNTER	675.00	5704	JACLYN HUNTER
8758	HOSPITAL CMS UPDATE - EXPENSE	70618	177.13	83225	KELLY WELLS
8758	HOSPITAL CMS UPDATE - REGISTRATION	70618WELLS	599.00	37905	KELLY WELLS

**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.