TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
April 25, 2019 – 2:30 o'clock p.m.
Classroom 7 - Eugene L. Geil Pavilion
Open Session – Assembly Rooms 1, 2 & 3
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Closed Session portion of the Agenda. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors.	3 min.	Standard
4	Oral Announcement of Items to be Discussed During Closed Session (Authority: Government Code, Section 54957.7)		
5	Motion to go into Closed Session		
6	Closed Session	1 Hour	
	a. Conference with Legal Counsel – Potential Litigation (Authority: Government Code, Section 54956.9(d) 2 (1 Matter)		
	b. Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committees (Authority: Health & Safety Code, Section 32155)		
	c. Reports Involving Trade Secrets (Authority: Health and Safety Code, Section 32106) Discussion Will Concern: Proposed new service or program Date of Disclosure: TBD		
	d. Approval of prior Closed Session Minutes		
	e. Public Employee Evaluation: Board Counsel (Authority: Government Code, Section 54957)		
7	Motion to go into Open Session		

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

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

	Agenda Item	Time Allotted	Requestor
8	Open Session		
	Open Session – Assembly Room 3 – Eugene L. Geil Pavilion (Lower Level) and Facilities Conference Room – 3:30 p.m.		
9	Report from Chairperson on any action taken in Closed Session (Authority: Government Code, Section 54957.1)		
10	Roll Call / Pledge of Allegiance	3 min.	Standard
11	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 14-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
12	Introduction of Barbara Vogelsang, Chief Nurse Executive	5 min.	CEO
13	Report from TCHD Foundation – Jennifer Paroly, Executive Director	10 min.	Standard
14	March 2019 Financial Statement Results	10 min.	CFO
15	New Business - None	---	--
16	Old Business – None	---	---
17	Chief of Staff a) Consideration of April 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 23, 2019. b) Consideration of Cardiology Privilege Card Revision	10 min.	Chief of Staff
18	Consideration of Consent Calendar **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.*** **(1) Administrative Committee** **a) Patient Care Policies & Procedures** 1) Defibrillator Checks Procedure 2) Patient Leave of Absence, Temporary Policy 3) Sitter Policy 4) Social Media, Nursing Policy (DELETE) 5) Swallowing, Food & Nutrition Considerations for Patients with Oropharyngeal Dysphagia Policy	5 min.	Standard

	Agenda Item	Time Allotted	Requestor
	b) Administrative Policies & Procedures 1) Employment of Relatives Policy 406 2) Incident Report – Quality Review Report (QRR) RL Solutions Policy 396 3) Medical Procedures and Interrogations Requested by Law Enforcement Policy 211 4) Recyclable Waste Policy 479 5) Social Media Policy 209 **c) Cardiac Rehab** 1) Fall Risk Assessment Policy (DELETE) **d) Intensive Care Unit** 1) Closure of Beds Policy (DELETE) 2) ICU Post-Op Heart Cart Policy **e) Medical Staff** 1) Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds Policy 8710-522 2) Prevention of Fire in Head and Neck Surgery Policy 8710-560 (DELETE) **f) NICU** 1) Consultation to Perinatal Unit Policy 2) Eye Examinations for Retinopathy Prematurity other High Risk Disorders Procedure 3) Pre/Post Weights for Breastfed Infants in NICU Procedure **g) Rehabilitation** 1) Home Evaluation Policy 504 2) Occupational Therapy Daily Note, Inpatient Policy 1202 (DELETE) 3) Occupational Therapy Daily Note, Outpatient Policy 1203 (DELETE) 4) Occupational Therapy Policy 702 5) Outpatient Team Conference & Meeting Policy 511 (DELETE) 6) Physical Therapy Policy 603 7) Provision of Rehab Services Not Provided by Tri-City Medical Center Policy 106 (DELETE) 8) Referrals for Rehabilitation Services Policy 509 9) Scope of Services Policy 104 10) Therapeutic Recreation Department Policy 901 **h) Surgical Services** 1) Scope of Service for SPRA Policy (DELETE) 2) Visitors in PACU Policy **i) Women and Newborn Services** 1) Placenta Release to Patient/Family Except for Those Sent to Pathology Policy		
	(2) Board Committees		
	A. Community Healthcare Alliance Committee Director Chavez, Committee Chair *(No meeting held in April, 2019)*		CHAC Comm.

	Agenda Item	Time Allotted	Requestor
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 1 *(No meeting held in April, 2019)* **C. Professional Affairs Committee** Director Reno, Committee Chair *(No meeting held in April, 2019)* **D. Audit, Compliance & Ethics Committee** Director Schallock, Committee Chair Open Community Seats – 2 *(Committee minutes included in Board Agenda packets for informational purposes)* 1) Approval of FY2019 Financial Statement Audit Proposal (3) Minutes – Approval of: a) Regular Board of Directors Meeting – March 28, 2019 b) Special Board of Directors Meeting – April 2, 2019 (4) Meetings and Conferences – None (5) Dues and Memberships - None		FO&P Comm. PAC Audit, Comp. & Ethics Comm. Standard
19	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
20	Reports (Discussion by exception only) (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (March, 2019) (d) Reimbursement Disclosure Report – March, 2019) (e) Seminar/Conference Reports 1) AHA Annual Meeting – Director Chavez	0-5 min.	Standard
21	Comments by Members of the Public NOTE: Per Board Policy 14-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
22	Comments by Chief Executive Officer	5 min.	Standard
23	Board Communications (three minutes per Board member)	18 min.	Standard
24	Report from Chairperson	3 min.	Standard
25	Total Time Budgeted for Open Session	1.5 hours	
26	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
April 10, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 04/26/2019 – 03/31/2021)

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 04/26/2019 through 03/31/2021:

- **BRAR, Karanbir MD/Internal Medicine (Coastal Hospitalists)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 4
April 10, 2019

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 05/01/2019 –04/30/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 05/01/2019 through 04/30/2021, 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:

- ATHILL, Charles, MD/Cardiology/Active Affiliate
- BENGS, Christopher, MD/Family Medicine/Active Affiliate
- BERNHARDT, Chad, MD/Emergency Medicine/Active
- BOBICK, Brian, DPM/Podiatric Surgery/Active
- CASTRO, Jorge, MD/Pediatrics/Active
- CONANT, Reid, MD/Emergency Medicine/Active
- DAY, Richard, MD/Internal Medicine/Active
- Dougherty, Colin, MD/Emergency Medicine/Active
- D'SOUZA, Gehaan, MD/Plastic Surgery/Provisional
- ELI, Bradley, DMD/Dentistry/Active Affiliate
- FARHOOMAND, Kaveh, DO/Internal Medicine/Active Affiliate
- FORTUNA, Robert, MD/Teleradiology/Active Affiliate
- GENTILUOMO, Jesse, MD/Emergency Medicine/Provisional
- JACOBS, Robert, MD/Otolaryngology/Active
- KARP, Michael, MD/Pediatrics/Active
- KAZEM, Fatima, MD/Teleradiology/Active Affiliate
- LY, Justin, MD/Teleradiology/Active Affiliate
- MORADI, Amir, MD/Otolaryngology/Active Affiliate

Attachment B

- NOVAK, Loren, DO/Family Medicine/Active
- ORDAS, Dennis, MD/Psychiatry/Active
- PADUGA, Remia, MD/Neurology/Active
- ROHER, Alexander, MD/Anesthesiology/Active
- SARKARIA, Paul, MD/Cardiology/Active
- SEUFERT, Kevin, MD/Family Medicine/Refer and Follow
- SPIEGEL, David, MD/Cardiology/Active
- YAKHNENKO, Ilya, MD/Internal Medicine/Provisional

RESIGNATIONS: (Effective date 04/30/2019 unless otherwise noted)

Automatic:

Voluntary:

- MILLER, Jessica, MD/Emergency Medicine
- MORRIS, Kenneth, MD/Pediatrics

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 10, 2019

ADDITIONAL PRIVILEGE REQUEST (Effective 4/26/2019, unless otherwise specified)

The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s):

- YOO, Frank K., MD — Neurosurgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
April 10, 2019

PROCTORING RECOMMENDATIONS (Effective 4/26/2019, unless otherwise specified)

• CRANDALL, Geoffrey MD	Anesthesiology
• DANG, Christopher DO	Emergency Medicine
• EIKERMAN, Eric MD	Anesthesiology
• RYEL, Justin MD	Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
April 15, 2019

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 4/26/2019 – 1/31/2021)

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 4/26/2019 through 1/31/2021:

- **BRATTON, Kayla PA-C/Allied Health Professional (TeamHealth)**
- **KELLY, Katherine CNM/Allied Health Professional (No. County Health Svcs.)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 3
April 15, 2019

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 5/1/2019 – 4/30/2021)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 5/1/2019 through 4/30/2021, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **ALLEN, Matthew, PA-C/Allied Health Professional**
- **BRADY, Kristina, AuD/Allied Health Professional**
- **BROCKMAN, Joe, PA-C/Allied Health Professional**
- **BROWNSBERGER, Richard, PA-C/Allied Health Professional**
- **CRESPO, Christopher, PA-C/Allied Health Professional**
- **GARBACZEWSKI, Stephanie, PA-C/Allied Health Professional**
- **HERMANSON, Kathleen, PA/Allied Health Professional**
- **JENKINS-Sebastiani, Christina, AuD/Allied Health Professional**
- **LISTER, Crystal, CNM/Allied Health Professional**
- **MCNALLY, Paul, NP/Allied Health Professional**
- **MURPHY, Kayla, CNM/Allied Health Professional**
- **PREGERSON, Heather, PA-C/Allied Health Professional**
- **SCHILLINGER, Stephan, PA-C/Allied Health Professional**
- **WEARY, Yong, CNM/Allied Health Professional**

RESIGNATIONS: (Effective date 04/30/2019 unless otherwise noted)

- **DEATRICK, Veronica, NP/Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 2 of 3
April 15, 2019

None

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
April 15, 2019

Attachment C

PROCTORING RECOMMENDATIONS (Effective 4/26/2019, unless otherwise specified)

- **SAVIC, Jessica PA** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Cardiology (Revised 1/19)

Provider Name:

Request	Privilege

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

BASIC QUALIFICATIONS: The Division of Cardiology consists of physicians who are Board Certified in Cardiovascular disease by the American Board of Internal Medicine or are actively progressing toward certification.
Applicants who are progressing toward Board Certification must complete formal training prior to applying for medical staff membership in the Division of Cardiology and must become Board Certified within five (5) years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee.

By virtue of appointment to the Medical Staff, all physicians are authorized to perform occult blood testing and order diagnostic and therapeutic tests, services, medications, treatments (including but not limited to respiratory therapy, physical therapy, occupational therapy) unless otherwise indicated.

COGNITIVE PRIVILEGES:

Initial Requirement: Must meet basic qualifications as outlined above.
Proctoring Requirement: A minimum of 6 cases proctored resulting in any combination of H&P'sand/or Consultations.
Reappointment Criteria: Documentation of 6 cases within the past two years is required.

May Include:

___ Admission of a Patient to Inpatient Services

___ Performance of a History and Physical Examination, including via telemedicine

___ Performance of a Cardiac Consultation, including via telemedicine

___ ~~Operation of Fluoroscopy Equipment~~
~~**Prerequisite Criteria:** Requires Current Fluoroscopy certificate.~~

ALLIED HEALTH PRACTITIONER SUPERVISOR PRIVILEGES

___ Supervision of an approved category of Allied Health Practitioner

SEDATION/ANALGESIAPRIVILEGES:

___ Moderate Sedation/Analgesia

Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

___ Deep Sedation Sedation/Analgesia
Initial/Reappointment Criteria: Per Medical Staff policy 8710-517

BASIC INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and have performed at least four (4) of each privilege requested within the previous 24 month period is required.
Proctoring Requirements: One(1) of each privilege requested.

Provider Name:

Request	Privilege

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of four (4)cases of each procedure requested within the previous 24 month period is required.

___ Venous cut-down & Percutaneous Central Venous Pressure Catheters

___ Insertion of Temporary Transvenous Cardiac Pacemaker

___ Elective Cardioversion

___ Swan-Ganz Catheter Insertion & Monitoring

___ **CARDIAC CATHETERIZATION PROCEDURES**

Initial Criteria: Must meet basic qualifications as outlined above and provide training and show current competency of have performed at least three-hundred (300) cases; if more than 12 months since completion of training, documentation of forty (40) cases within two (2) years prior to application is required.
Proctoring Requirements: Five (5) cases
Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of forty (40)cases within the previous 24 month period is required.

Includes:

___ RIGHT Cardiac Catheterization

___ LEFT Cardiac Catheterization

___ Coronary Arteriography

Operation of Fluoroscopy Equipment
Prerequisite Criteria: Requires Current Fluoroscopy certificate.

INTERVENTIONAL CARDIOLOGY – PERCUTANEOUS CORONARY INTERVENTIONS (PCI)

Initial Criteria: Must meet basic qualifications as outlined above and requires training & two-hundred fifty (250) cases; if more than 12 months since completion of training, documentation of seventy (75) cases within the two years prior to application.

Proctoring: Five (5) Cases

Reappointment Criteria: In order to maintain this privilege bundle, competency criteria of Seventy five (75) cases of which twenty (20) must be done at TCMC within the previous 24 month period

___ Percutaneous Coronary Intervention

___ ~~Percutaneous Transluminal Coronary Angioplasty (PTCA)~~

___ ~~Thrombectomy~~

Provider Name:

Request	Privilege

___ ~~Intra-aortic Balloon Pump Insertion & Removal (IABP)~~

___ Temporary Percutaneous Left Ventricular Assist Device (Impella) (Requires Certificate)

___ Rotational Atherectomy (Requires Certificate)

___ Orbital Atherectomy (Requires Certificate)

SPECIAL PROCEDURES

Initial Criteria: Must meet basic qualifications as outlined above and the specific criteria indicated below.

Permanent Pacemaker Insertion (single/dual/biventricular chamber) and/or intra-cardiac defibrillator (ICD) (single/dual/biventricular chamber) requires proof of completion of fellowship training or twenty-five (25) cases.
Pericardiocentesis: Requires a Fluoroscopy Certificate
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation requires completion of accredited fellowship in Clinical Cardiac Electrophysiology, Board Certification or eligibility & twenty (20) cases within the past 12 months prior to application.
Transesophageal echocardiography (including passing the probe) requires documentation of training or a course.

Proctoring Requirements:

Permanent Pacemakers/ICDs: two (2)
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: two (2)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: two (2)
Transesophageal echocardiography: two (2)

Reappointment Criteria:

Permanent Pacemaker/ICD cases: ten (10)
Pericardiocentesis: one (1)
Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation: Twenty (20)
Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation: Twenty (20)
Transesophageal echocardiography: ten(10)

___ Permanent Pacemaker/ICD Insertion

___ Pericardiocentesis

___ Electrophysiologic Testing with Ablation, excluding Atrial Fibrillation Ablation

___ Electrophysiologic Testing with Ablation, including Atrial Fibrillation Ablation

___ Transesophageal echocardiography

Provider Name:

Request	Privilege

NON-INVASIVE PROCEDURES:

Initial Criteria: Must meet basic qualifications as outlined above and be a cardiologist with fellowship training and is an active reading panel participant and has sufficient case volumes to fulfill reappointment volume requirements as outlined below for each procedure requested.

Proctoring Requirements:

EKG: twenty five (25)
Stress ECHO: two (2)
Thoracic ECHO: two (2)
Holter Monitor: two (2)
Treadmill: two (2)

Reappointment Criteria:

EKG: five hundred (500) or active reading panel member as attested by Division of Chief or designee.
Stress Echo: five (5) Documentation of Stress Echos performed at other facilities (including the physician's office) will count towards this requirement.
Thoracic Echos: two hundred (200) or active reading panel member as attested by Division of Chief or designee.
Holter Monitor: forty (40), of which ten (10) must be performed at TCMC or active reading panel member as attested by Division of Chief or designee.
Treadmill: fifty (50) or active reading panel member as attested by Division of Chief or designee.

___ EKG

___ Stress Echo

___ Thoracic Echo

___ Holter Monitor

___ Treadmills

___ **PERIPHERAL VASCULAR INTERVENTIONAL PROCEDURES** (Refer to Medical Staff Policy # 8710-504 for Initial, Proctoring, and Reappointment Criteria)

___ Peripheral Angiography - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ Carotid

___ Cerebral

___ Extremity

___ Pulmonary

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Cardiology (Revised 1/19)

Provider Name:

Request	Privilege

___ Thoracic

___ Visceral

Peripheral Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ Angioplasty

___ Drug infusion

___ Stent graft

___ Stent placement

___ Thrombolysis

Venography and Venous Intervention - By selecting this privilege, you are requesting the core privileges listed immediately below. If you do not want any of the core privileges below, strikethrough and initial the privilege(s) you do not want.

___ IVC filter

___ Stent

___ Tissue plasminogen activator (tPA)

___ Venous Sampling

___ Venous Thrombolysis

_____

Print Applicant Name

_____

Applicant Signature

_____

Date

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Cardiology (Revised 1/19)

Provider Name:

Request	Privilege

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

ADMINISTRATION REVIEW CONSENT AGENDA
April 15th, 2019

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Defibrillator Checks Procedure	NEW	Forward to BOD for Approval
2. Patient Leave of Absence, Temporary Policy	3 Year Review, Practice Change	Forward to BOD for Approval
3. Sitter Policy	3 Year Review, Practice Change	Forward to BOD for Approval
4. Social Media, Nursing Policy	DELETE	Forward to BOD for Approval
5. Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy	Practice Change	Forward to BOD for Approval
Administrative Policies & Procedures		
1. Employment of Relatives Policy 406	3 Year Review, Practice Change	Forward to BOD for Approval
2. Incident Report-Quality Review Report (QRR) RL Solutions Policy 396	3 Year Review, Practice Change	Forward to BOD for Approval
3. Medical Procedures and interrogations Requested by Law Enforcement Policy 211	NEW	Forward to BOD for Approval
4. Recyclable Waste Policy 209	NEW	Forward to BOD for Approval
5. Social Media Policy 479	3 Year Review, Practice Change	Forward to BOD for Approval
ardiac Rehab		
1. Fall Risk Assessment Policy	NEW	Forward to BOD for Approval
Intensive Care Unit		
1. Closure of Beds Policy	DELETE	Forward to BOD for Approval
2. ICU Post-Op Heart Cart Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Medical Staff		
1. Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds Policy 8710-522	3 Year Review	Forward to BOD for Approval
2. Prevention of Fire in Head and Neck Surgery Policy 8710-560	DELETE	Forward to BOD for Approval
NICU		
1. Consultation to Perinatal Unit Policy	2 Year Review	Forward to BOD for Approval
2. Eye Examinations for Retinopathy Prematurity other High Risk Disorders Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
3. Pre/Post Weights for Breastfed Infants in NICU Procedure	2 Year Review, Practice Change	Forward to BOD for Approval
Rehabilitation		Forward to BOD for Approval
1. Home Evaluation Policy 504	3 Year Review, Practice Change	Forward to BOD for Approval
2. Occupational Therapy Daily Note, Inpatient Policy1202	DELETE	Forward to BOD for Approval
3. Occupational Therapy Daily Note, Outpatient Policy1203	DELETE	Forward to BOD for Approval
4. Occupational Therapy Policy 702	3 Year Review	Forward to BOD for Approval

ADMINISTRATION REVIEW CONSENT AGENDA
April 15th, 2019

CONTACT: Barbara Vogelsang, CNE

Policies and Procedures	Reason	Recommendations
5. Outpatient Team Conference & Meeting Policy 511	DELETE	Forward to BOD for Approval
6. Physical Therapy Policy 603	3 Year Review	Forward to BOD for Approval
7. Provision of Rehab Services Not Provided by Tri-City Medical Center Policy 106	DELETE	Forward to BOD for Approval
8. Referrals for Rehabilitation Services Policy 509	3 Year Review, Practice Change	Forward to BOD for Approval
9. Scope of Services Policy 104	3 Year Review	Forward to BOD for Approval
10. Therapeutic Recreation Department Policy 901	3 Year Review, Practice Change	Forward to BOD for Approval
Surgical Services		
1. Scope of Service for SPRA Policy	DELETE	Forward to BOD for Approval
2. Visitors in PACU Policy	3 Year Review, Practice Change	Forward to BOD for Approval
Women and Newborn Services		
1. Placenta Release to Patient/Family Except For Those Sent To Pathology Policy	3 Year Review, Practice Change	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**DEFIBRILLATOR CHECKS**
Purpose:	**To ensure proper functioning of the defibrillator to ensure patient safety.**
Supportive Data:	**A defibrillator is a life support equipment used for the purpose of sustaining life, and whose failure to perform its primary function will lead to patient death in the absence of immediate intervention.**
Equipment:	**Zoll Defibrillator M® series**

A. **POLICY:**

1. **Twenty-four (24) hour units will check defibrillator every shift while unit is open.**
2. **Episodic unit (i.e., procedural areas) shall check defibrillators once a day when unit is open.**

B. **PROCEDURE:**

1. Check unit cleanliness and inspect cables and connectors for integrity.
   a. ECG electrodes should not be pre-attached to the leads.
2. Ensure ~~that~~ **there is** ~~you have~~ a charged battery in the unit – testing will be performed with the unit unplugged from the power supply.
3. Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit.
4. Ensure the Multi-Function Cable is plugged into the unit.
   a. The Multi-Function Cable should not be plugged into the test connector.
5. Switch to monitor, listen for four beep tone. The message MONITOR should display.
   a. If **staff** ~~you~~ need to adjust the time or date on the unit, depress the softkey on the far right prior to switching to MONITOR and adjust as needed (this should be performed every two weeks).
6. Switch to PACER and set to a rate of 150 per minute.
7. Press recorder button.
8. Pacer pulses occur every two large divisions.
9. Press 4:1 button, pulses occur every 8 large divisions.
10. Stop recorder
    a. Note that signing, dating and retaining the recorder output is not a requirement.
11. Set PACER OUTPUT to 0 mA and ensure that there is no CHECK PADS message.
12. **Disconnect Multi-Function Cable from the unit.** Set PACER OUTPUT to 16 mA and ensure that there is a CHECK PADS message and alarm.
13. Connect multifunction cable to test connector~~,~~.
14. Press Clear Pace Alarm softkey; CHECK PADS message will disappear and pace alarm stops.
15. Disconnect multifunction cable from test connector~~,~~.
16. Switch unit to DEFIB and set energy to 30 joules
    a. The messages CHECK PADS and POOR PAD CONTACTS will alternately display.
17. Plug the Multi-Function Cable into its test connector.
    a. The message DEFIB PAD SHORT will display.
18. Press the CHARGE button on the front panel or on the apex paddle handle.
19. Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules.
    a. The message will read DEFIB 30J READY
    b. The strip chart recorder will print a short strip indicating TEST OK energy delivered if the unit delivered energy within specifications. ~~,~~ Note that signing, dating and retaining the recorder output is not a requirement.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
NEW, 12/18	01/19	01/19	n/a	n/a	n/a	04/19	n/a	

c. During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules.
d. If TEST FAILED appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.

20. Plug device back into the electrical socket after testing is complete.

~~20.~~21. ~~Ensure Multi-Function Cable is plugged into the unit after testing is complete.~~

C. FORM(S):

~~21.~~1. Tri-City Medical Center Stand Alone Defibrillator Checklist

UNIT:___________________________

TRI-CITY MEDICAL CENTER STAND ALONE DEFIBRILLATOR CHECKLIST

MONTH/YEAR:____________________

Legend: ✓ = Present/Checked R = Replaced — Defib Check 1 / Defib Check 2	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DEFIBRILLATOR		Yes, Defibrillator # or ID:																													
DEFIB TESTED (PACER/DEFIB) (DC 30J) (Check unplugged)																															
DEFIB BATTERY CHECKED/ CHANGED (2.5 Hr Life w/cont. use)																															
TIME UPDATED TWICE MONTHLY																															
DEFIBRILLATOR		Yes, Defibrillator # or ID:												No																	
DEFIB TESTED (PACER/DEFIB) (DC 30J) (Check unplugged)																															
DEFIB BATTERY CHECKED/ CHANGED (2.5 Hr Life w/cont. use)																															
TIME UPDATED TWICE MONTHLY																															
DEFIBRILLATOR		Yes, Defibrillator # or ID:												No																	
DEFIB TESTED (PACER/DEFIB) (DC 30J) (Check unplugged)																															
DEFIB BATTERY CHECKED/ CHANGED (2.5 Hr Life w/cont. use)																															
TIME UPDATED TWICE MONTHLY																															
DEFIBRILLATOR		Yes, Defibrillator # or ID:												No																	
DEFIB TESTED (PACER/DEFIB) (DC 30J) (Check unplugged)																															
DEFIB BATTERY CHECKED/ CHANGED (2.5 Hr Life w/cont. use)																															
TIME UPDATED TWICE MONTHLY																															
SIGNATURE OF PERSON COMPLETING FIRST DEFIBRILLATOR CHECK																															
SIGNATURE OF PERSON COMPLETING SECOND DEFIBRILLATOR CHECK NOTE: Episodic unit (i.e. procedural areas) shall check defibrillators once a day when unit is open																															

Revision CPP 01.2019

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**8/01**	**SUBJECT:**	**Patient Leave of Absence, Temporary**
REVISION DATE:	**12/01, 6/02, 6/03, 8/05, 9/07, 03/11**	~~**POLICY NUMBER: III.C**~~	

Patient Care Services Content Expert:	**01/19**
Clinical Policies & Procedures Committee Approval:	**~~04/15~~02/19**
Nurse~~ing~~ Executive Committee~~uncil~~ Approval:	**03/19**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/15~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~08/15~~ n/a**
Board of Directors Approval:	**08/15**

A. **PURPOSE:**
1. It may be necessary for a patient to be temporarily absent from the hospital for medical reasons.

B. **POLICY:**
1. All temporary absences require a physician order.
2. It must be understood by the patient that he/she is not discharged from the hospital.
3. The day on which the patient began a leave of absence is treated as a day of discharge, and is not counted as an inpatient day unless the patient returns to the facility by midnight of the same day.

C. **PROCEDURE:**
1. During the course of the stay, it is the physician's responsibility to provide written documentation in the order or progress notes regarding:
   a. Stability of patient for transfer in the case of absence for medical procedures
2. Prior to transfer for medical procedures:
   a. The patient or patient representative will sign "Consent for Transfer for Medical Treatment"
   b. The transferring unit shall schedule the procedure with the appropriate department(s) at the receiving location or hospital (i.e., CT scan, echocardiogram).
   c. The physician shall designate mode of transport (i.e., ambulance) and level of transport (i.e. Basic Life Support or Critical Care Transport Ambulance).
      i. Oncology patients being transported for Radiation Therapy can only be transported via ambulance.
         1) For ~~forensic~~ **justice involved** patients, custody staff will accompany patient.
   d. The transferring unit shall make transportation arrangements.
   ~~d.~~e. The primary nurse will attempt to provide hand off to the receiving facility.
   ~~e.~~f. Copies of pertinent components of the medical record shall accompany the patient.
3. Receiving facility
   a. The receiving medical facility shall obtain an additional informed consent from the patient or patient representative when appropriate.
   b. The receiving physician/staff shall be responsible for continuing medical care.

c. Following completion of the testing/procedure(s), the receiving medical facility shall arrange for appropriate return transportation of the patient and components of the medical record.

d. The physician sending the patient back to TCMC shall document the patient's condition prior to departure.

e. Consent for the return trip is not necessary unless a change in mode of transportation is indicated.

D. **FORM(S):**

1. Consent to Transfer for Medical Treatment - Sample ~~Form~~

SAMPLE

FORM 9-3

CONSENT TO TRANSFER FOR MEDICAL TREATMENT

Patient's Name: _____

Your/The patient's attending physician is Dr. *(physician name)* _____ _____. The physician who will perform the procedure(s) described below is Dr. *(physician name)* _____. The facility at which the procedure(s) will be performed is *(facility name)* _____ _____

Your/the patient's physician has recommended that you/the patient should be transferred to *(name of receiving facility)* _____ where the following procedure(s) will be performed *(name of procedure)* _____ _____ by or under the supervision of Dr. *(name of receiving physician)* _____ and you have separately given your consent for the performance of this procedure(s).

Upon your consent, arrangements will be made to transfer you/the patient from this hospital to the facility named above. Before you give consent, you have the right to be informed of any risks or complications which may result from transferring you/the patient.

Your/the patient's physician has recommended that the method of transportation which will be used to transfer you/the patient will be *(specify method of transportation)* _____ _____ and, except in those cases in which an employee of the hospital accompanies a patient during the transfer, the hospital does not assume any responsibility for your/the patient's care during the transfer or during your/the patient's absence from the hospital.

TEMPORARY ABSENCE RELEASE FOR TRANSFER TO ANOTHER FACILITY

Having given my permission to the attending physician(s) and obtained his/her permission to be absent from the hospital for the performance of a medical procedure(s) at *(name of receiving facility)* _____ _____ from *(time)* _____, *(date)* _____ _____ to *(approximately) (time)* _____, *(date)* _____, I assume all responsibility for myself, or *(name of patient)* _____, who is my *(relationship)* _____ during the temporary absence and I hereby release *(name of transferring hospital)* _____ _____, its employees and the attending physician(s) from all responsibility during this absence and for my/the patient's condition as a result thereof.

(over)

SAMPLE

Form 9-3 Consent to Transfer for Medical Treatment

My signature below constitutes my acknowledgment that (1) I have read and agree to the foregoing; (2) that the plans for my/the patient's transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my/the patient's physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to my/the patient's transfer to the facility named above for the performance of the medical procedure.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners.

Date: _____ Time: _____ AM / PM

Signature: _____
(patient/legal representative)

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(legal representative)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 03/02

SUBJECT: Sitter Policy

REVISION DATE(S): 11/02, 02/03, 03/03, 02/05, 05/05, 07/06, 11/06, 11/07, 12/07, 10/10, 01/11

~~POLICY NUMBER: VIII.I~~

Patient Care Services Content Expert Approval:	**05/18**
Clinical Policies & Procedures Committee Approval:	**~~05/14~~02/19**
Nurse Executive Committee:	**~~10/14~~03/19**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~01/15~~ n/a**
Board of Directors Approval:	**01/15**

A. **DEFINITION(S):**

1. **Direct and continuous observation: patient within view at all times including when patient is off of the unit to procedures or tests unless instructed by the primary nurse or procedure/test staff.**
2. **Sitter: role of providing direct and continuous observation or suicide observation for assigned patient(s).**
3. **Suicide Observation: direct continuous one to one (1:1) observation where a designated staff member is within arm's length of the patient at all times, accompanies the patient off of the unit to procedures or tests, and remains with patient unless instructed by the primary nurse or procedure/test staff.**

B. **PURPOSE:**

1. To provide guidance to the health care team **to:**
   - a. **Ensure**~~for the use of sitters for~~ patient safety and ~~to~~ protect the patient from harm~~;~~
   - b. **Identify** the circumstances under which ~~such use~~**a sitter** shall be permitted~~; and~~
   - c. **Understand** the procedure to be followed when all alternatives have been exhausted and proven ineffective in maintaining patient safety.
   - ~~a. Outline the responsibilities of health care team members.~~

C. **POLICY:**

1. **Suicide**~~1:1 constant~~ observation ~~for suicide~~ **and** precautions shall be instituted immediately for any patient who has either verbalized suicidal ideation, a suicidal plan, or has made a recent suicide attempt **per Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide.**
   - ~~a. The admitting physician shall be notified to determine the need for a psychiatric evaluation.~~
   - ~~b. The patient shall be placed in a safe environment in a room close to the nurse's station as soon as possible.~~
   - ~~c. Social Services may be notified to assist in managing the patient's care.~~
   - ~~d.~~a. The sitter shall review the **Environmental Safety Guidelines for Suicidal Patient**~~suicide precaution guidelines (see section on page 3)~~ each time they are assigned to a suicidal patient.

2. Unless ~~an order is for 1:1~~**suicide** observation **is required, a** sitters can be assigned to more than one patient in the same room as deemed appropriate by the ANM/designee. All attempts shall be made to cohort patients depending on their situation. Whenever possible the patient will be placed in a room close to and in view of the nurse's station.
3. **Sitter is not relieved of their duties and responsibilities until their relief person arrives and hand-off is provided.**
4. When family requests a sitter, and it is determined that the patient does not meet the criteria for a sitter, then the family is responsible to contact, contract, and pay for the use of the sitter.
   a. A list of agencies is available for family members who choose to obtain caregiver services at their own expense.
   b. Family funded caregivers shall be required to sign in with the Staffing Office prior to the start of each shift and shall complete the Non-TCMC Employment Packet.
5. A physician order for sitter for a non-suicidal patient is not required. If the physician orders a sitter, discontinuation of the patient sitter assignment requires a physician order after discussion with the physician, and other members of the health care team.
6. Every 4 hours, attempts shall be made to employ alternatives to the use of sitter while still ensuring patient safety. Refer to Sitter – Alternatives to Use for possible alternatives.

D. **ASSISTANT NURSE MANAGER (ANM)/DESIGNEE RESPONSIBILITIES~~PROCEDURE~~:**

1. ~~An Assistant Nurse Manager (ANM) or designee d~~Determines ~~there is a~~ **the** need **for**~~to provide~~ a sitter based on clinical data, potential patient safety concerns, unique patient care needs~~,~~ **or** potential danger to self **(suicide)** or others~~, or a 72-hour hold~~.
2. ~~The ANM or designee will r~~Review the need for a sitter with the **Registered Nurse** (RN). The determination must be made that alternatives have been ineffective, causes for confusion/agitation have been identified and treated if applicable, and that there is clinical justification of a need for a sitter. Refer to Sitter – Decision Tree for Use.
3. ~~The ANM/designee shall e~~Evaluate the need to continue the sitter at least every 4 hours and/or as patient status changes.
   a. Any patient with a sitter, who is being transferred to a new unit, must be re-evaluated for ongoing sitter needs prior to transfer.
4. ~~The ANM/designee is responsible for the o~~Orientation ~~of~~ the sitter **to the unit as needed**.

E. **PRIMARY RN RESPONSIBILITIES:**

1. **Confirm**~~The RN receives~~ approval for use of a sitter **with**~~from~~ the ANM/designee.
2. ~~Nursing staff shall e~~Explain to the patient and/or family the rationale for the safety precautions.
3. **Ensure sitter:**
   a. Receives safety instructions at the beginning of shift and as needed
   b. Is covered by another health care provider to document in the medical record and for meal/break.

~~3.~~**4. Attempt to employ alternatives to the use of a sitter every four (4) hours, while still ensuring patient safety**

F. **SITTER RESPONSIBILITIES:**

1. ~~The sitter r~~Receives ~~the~~ assignment and reports to the **ANM/designee**~~assigned nurse on arrival to the unit~~.
2. ~~The sitter shall p~~Perform all duties in a manner that respects all patient rights. ~~The following are the responsibilities of the sitter:~~
3. Direct and continuous observation of the patient at all times.
   a. If a sitter is assigned more than one patient they must call for assistance when unable to visualize both patients.
   b. Sitters are prohibited from **the following activities while assigned to patients:**
      i. ~~Leaving the patient unattended at any time,~~
      ii. Engaging in any activit**iesy** which distracts ~~the sitter's~~ attention from the patient~~, and~~
      iii. Giving any advice regarding personal matters **to the patient or family.**

iv. **Documenting Activities of Daily Living (ADLs) in the patients' room**
1) **Work Stations on Wheels (WOWs) are not allowed in patients' rooms for use by sitters.**

~~4.~~**v.** **Initiating, working on, or completing homework, sleeping, reading, drawing, coloring, painting, sketching, needle work (sewing, knitting, crocheting, etc.) or playing games using printed or electronic devices.** ~~Homework and reading are prohibited.~~

~~i.~~**vi.** **Using electronic devices e.g., personal cell phones, laptops, ~~k~~Kindle, iPads, iPods etc.**

c. In the Emergency Department (ED)~~,~~
i. The sitter must remain in the doorway at a safe distance from the patient, **e.g., your arm distance from the patient, doorway**
~~b.~~**ii.** **Ensure**~~With~~ the blinds **remain** open **at all times.**

~~5.~~**4.** Accompany the patient off unit to tests or procedures and remain with the patient, unless instructed otherwise by the assigned nurse or the individual performing the test.

~~6.~~**5.** **Notify the assigned nurse and receive permission** ~~If the sitter is~~ asked by family or visitors of the patient to temporarily leave the room~~, he/she must notify the assigned nurse and receive permission~~.

~~7. Vital sign measurement and documentation as ordered by the physician.~~
~~a. In the ED, vital signs are measured and documented at least every 4 hours.~~

~~8. Input and Output measurement and documentation~~

~~9.~~**6.** **Provide ~~P~~p**ersonal care (i.e., oral care, skin care, foot care, bathing, toileting, position changes, linen changes, shampoo and hair care)

~~10.~~**7.** **Provide ~~N~~n**utritional care (i.e., feeding or assisting with meals, reporting and documenting percent of food eaten by patient)

~~11.~~**8.** Maintain safety precautions as directed by the primary nurse/designee to include but not limited to:
a. Ensure side rails are up
~~a.~~**b.** Ensure bed is in low and locked position
~~b. Check and document restraints per procedure~~
c. Assist **within** ~~in~~ restraint application **and removal** ~~as~~ directed**~~ion~~ by the RN** ~~of clinician leading team in intervention~~

~~12.~~**9.** Assist qualified caregivers with range of motion, transfers, ambulation, and other activities as directed by the primary nurse/designee.

~~13.~~**10.** Maintain a neat, clean, and organized environment.

~~14.~~**11.** Introduce self to the patient and interact with the patient as appropriate.
a. Reinforce information the nurse has provided regarding procedures and tests; provide clear and direct information to the patient.
b. Listen, but do not offer advice or counseling.
i. Refer to RN for sensitive issues.
c. Conceal extreme emotional response from the patient (i.e., fear, sympathy, disgust, irritability).

~~15.~~**12.** Notify the primary nurse/designee immediately for any alarms, hazards, or safety risks to the patient.
a. Check observable areas for sharps, matches, lighters, illegal drugs or any other item the patient may use to harm self or others.
b. Notify the primary nurse/designee immediately with concerns or questions.

~~16.~~**13.** Inform primary nurse/designee of any behavior that may be unsafe.
a. If patient becomes agitated or violent, contact Security, RN and ANM and they will determine appropriate next steps for assistance.

~~17.~~**14.** Report changes in patient clinical condition to primary nurse or designee immediately.

~~18.~~**15.** Obtain report at the beginning of the shift and provide report to the primary nurse/designee and relief person at the end of shift.

~~19.~~**16.** Ensure there is direct and immediate coverage for rest-periods and meal breaks.
a. The sitter shall receive breaks in accordance with department procedures.

b. The sitter is responsible to arrange these with the RN or designee at the beginning of the shift and is not relieved of duty until the relief person arrives.

~~20. Homework and reading are prohibited.~~

~~G. SUICIDE PRECAUTIONS GUIDELINES:~~

~~1. Observe the patient to ensure safety and the patient's airway is not compromised.~~
~~2. Sharp objects and tourniquets will not be left in the patient's room.~~
~~3. Nursing staff must ensure that all prescribed medications are swallowed.~~
~~4. Any further statements or threats and/or descriptions of a plan by the patient must be reported immediately to the Registered Nurse for further evaluation and level of safety.~~
~~5. Patient's are to be kept under visual observation at all times by nursing staff. Patients are not to be left alone at any time.~~
~~6. Patient privacy and dignity must be considered. Prior to patient accessing the bathroom, remove any towels, sheets or other ties that could be used to tie fixtures. Escort patient and do not allow the door to be closed. Stay outside open door. Check patient by conversing at least once a minute and elicit a response.~~
~~7. Educate and explain to visitors that no sharps can be brought in to the room to ensure patient's safety. In the event that the visitor is not cooperative with requests to remove items, call Security.~~
~~8. If the patient attempts to leave, call a Dr. Strong to detain the patient for his/her own safety and contact with primary physician. For patients on suicide precautions, the patient is evaluated by a psychiatrist. Application of restraints must be in accordance with Restraint Policies and Procedures.~~
~~9. Dietary will supply trays with paper containers and plastic ware to patients that are under suicide precautions. When the patient is finished eating they are to be disposed of outside the patient's room.~~
~~10. In the event the patient elopes, call the Security, ANM/designee, Liaison, and physician and notify Oceanside Police Department. Provide the police with a description of the patient.~~
~~11. Patients must be escorted at all times to tests and procedures and the 1:1 visual contact must be adhered to.~~
~~12. Points to emphasize:~~
~~a. Family members (when appropriate and with patients consent) may be provided with education regarding the patient's medical and emotional condition, safety factors and provided with community resources.~~
~~b. Patients on suicide precautions may try to negotiate a contract for safety to discontinue the 1:1 sitter. Contracts should never replace the 1:1 policy. Sitters should never leave the room even when family members are present.~~
c. ~~The sitter will be utilized for suicide precautions until the psychiatrist has identified that the inpatient is no longer at risk to cause harm to themselves or others.~~

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

1. **Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide**
2. **Environmental Safety Guidelines for Suicidal Patient**
~~1.~~3. Sitter Alternatives to Use
~~2.~~4. Sitter Decision Tree for Use
~~3.~~5. **Sitter Responsibilities~~ Patient Safety Technician Agreement~~

Environmental Safety Guidelines for Suicidal Patient

Environment for patients at risk for suicide should be checked each shift **including but not limited to the following:**

Sharp Objects Removed from Room

- Remove all sharp objects e.g., needles, scalpels, knives, scissors, nail files, coat hangers, cutlery, glass items

Patient Belongings That Can Be Used to Inflict Self Harm Removed From Room

- Clothing with any type of strings, shoe laces, ties, drawstrings, belts or straps, **socks**
- This includes but is not limited to: patient medications, glass or sharp items, matches or lighter, batteries toiletry items containing alcohol, peroxide, aerosol spray can, curling iron, hair dryer, razor, hand rub/sanitizer, dental floss, jewelry and illegal substances, **washclothes**
- **Allowable items:**
  - Cordless electric razor
  - Eyeglasses
  - Non-breakablege or ingestible toiletries

Remove to Reduce Risk of Hanging (Ligature Points) and Eliminate Potentially Harmful Objects:

- Plastic Bags: Garbage container, linen containers and all plastic bags
- Linen: Remove extra linen (sheets, towels, pillowcases, blankets, gowns, draw sheets etc.)
- Tubing: suction and IV tubing (excessive)
- Oxygen tubing and flowmeter (unless required for continuous use)
- Cords: electric, telephone, bed, call button and detachable window blinds, curtains
- Monitoring equipment (BP/EKG cables) unless required for continuous monitoring
- Room:
  - Bathroom plumbing, fixtures
  - Bedframe, rails
  - Coat hooks
  - Curtains/blinds and curtain rails for windows or doors, tracking, wires for nets
  - Doors/cabinets handles, hooks, hinges or gaps between door and frame
  - Door closures should be mounted on outside of door
  - Furniture for potential barricade
  - Grab bars
  - Light fixtures such as lamps, bulbs, shades, cords
  - Shelving hinges, brackets, fixtures
  - Window - ensure windows are secured

Dietary:

- Ensure disposable cups, plates and plastic sporks are used and removed after meals/snacks
- Aluminum cans

Hand-off:

- Initiation of suicide precautions and 1:1 observation communicated during hand-off e.g., shift-to-shift, meal breaks, bathroom, anytime a patient is hand-off to another care provider.

Visitors:

- Monitor any item(s) brought in by visitors. Remove items considered unsafe and return it to visitor when they leave the facility.

Note: Add to IView Environmental Safely-Sharps container secured in room. Remove from room if not secured.

Sitters Alternatives to Use During Care

- ***Psychosocial Alternatives***
  (a) Diversion
  (b) Family interaction
  (c) Orientation
  (d) Pastoral visit
  (e) Reassurance
  (f) Reading
  (g) Relaxation techniques
  (h) Interpreter services
  (i) Personal possessions available
  (j) Quiet area
  (k) One-on-one discussion
  (l) Decreased stimulation
  (m) Change in environment
  (n) Re-establishing communication
  (o) Setting limits

- ***Environmental Alternatives***
  (a) Commode at bedside
  (b) Decreased noise
  (c) Music/TV
  (d) Night light
  (e) Room close to nursing station
  (f) Call light within reach
  (g) Bed alarm in use
  (h) Specialty low bed
  (i) Sensory aides available (glasses, hearing aide)
  (j) Decreased stimulation
  (k) Providing a quiet area
  (l) Physical activity
  (m) Orientation

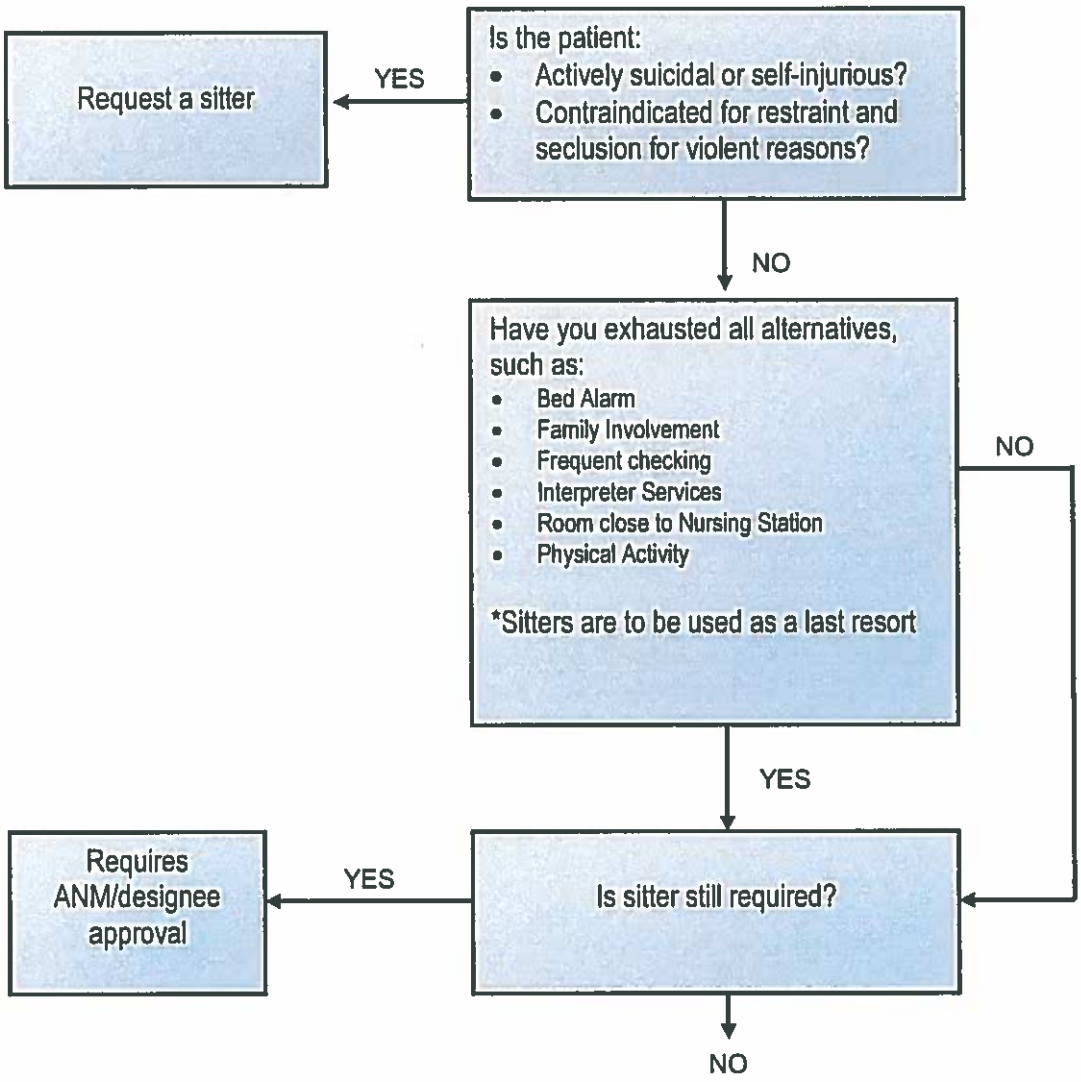
- ***Physiological Alternatives***
  (a) Toileting
  (b) Fluids/nutrition/snack
  (c) Positional devices
  (d) Pain intervention
  (e) Assisted ambulation
  (f) Re-positioning
  (g) Rest/sleep
  (h) Providing assistance
  (i) Additional warmth
  (j) Decreased temperature
  (k) Check lab values
  (l) Pharmacy consult

Sitter Decision Tree for Use

Patients must first meet the following criteria in order to be considered for a sitter:

- Their behavior is out of control – i.e., increased motor activity, impulsive behavior with lack of judgment, inability to tolerate environmental stimuli, faulty sense of reality resulting in hitting out or running away.*

*This does not include psychiatric patients who may be a danger to themselves or others because of their condition



Tri-City Medical Center
Oceanside, California

SITTER RESPONSIBILITIES

Name: _____ Date: _____

Registry (If applicable) : _____

1. The shift ends when the relief sitter arrives or when the order for sitter is discontinued.
2. The ultimate responsibility for the patient with the sitter remains with the primary RN.
3. The RN shall determine the extent of patient care and the degree of supervision necessary.
4. Sitter may be called away to assist another RN if the assigned patient's RN is with the patient.
5. Sitter must arrange their breaks with the RN and notify the RN upon their departure and return.
6. The sitter role is that of a companion and observer for safety issues.
7. Sitter duties:
   a. Direct and continuous observation of the patient in the absence of the RN
   b. I and O measurement and give values to RN or designee to document. Personal care including but not limited to: oral care, skin care, foot care, bathing, toileting, position changes, linen changes, shampoo and hair care.
   c. Nutritional care: feeding or assisting with meals and reporting percent eaten by patient.
   d. Maintenance of safety precautions: siderails up, checking and documenting restraints per procedure, bed low and locked, and others as directed by the RN.
   e. Assisting with ROM, transfers, ambulation and other activities as directed by the RN.
   f. Maintenance of a neat, clean, and organized environment.
   g. Immediate notification of the RN/Charge Nurse for any alarms, hazards, or safety risks to the patient.
   h. Helpfulness toward and support of family members and visitors.
   i. In the Emergency Department (ED)
      i. The sitter must remain in the doorway at a safe distance from the patient, e.g., your arm distance from the patient, door way
      ii. Ensure the blinds remain open at all times.
8. Professional appearance, demeanor, and speech are the expectation at all times
9. Sitters are prohibited from the following activities while assigned to patients:
   a. Engaging in any activities which distracts attention from the patient
   b. Giving any advice regarding personal matters to the patient or family.
   c. Documenting Activities of Daily Living (ADLs) in the patients' room
      i. Work Stations on Wheels (WOWs) are not allowed in patients' rooms for use by sitters.
   d. Initiating, working on, or completing homework, **sleeping,** reading drawing, coloring, painting, sketching, needle work (sewing, knitting, crocheting, etc.,) or playing games using printed or electronic devices.
   e. Using electronic devices e.g., personal cell phones, laptops, Kindle, iPads, iPods etc.

For any questions regarding the sitter responsibilities please contact the Assistant Nurse Manager (ANM)/Relief Charge Nurse.

I have read the sitter/ responsibilities and agree to perform my job duties in accordance with this agreement.

Signature: _____ Date: _____

Signature: _____ Date: _____

PATIENT SAFETY TECHNICIAN AGREEMENT

Name: _____ Date: _____

Registry: _____

PATIENT SAFETY TECHNICIANS (PST):

1. Arrangements for PSTs are made through the staffing office
2. The shift ends when the relief PST arrives or when the order for PST is discontinued.
3. The ultimate responsibility for the patient with the PST remains with the Tri-City Medical Center Registered Nurse (RN).
4. The RN shall determine the extent of patient care and the degree of supervision necessary
5. PSTs may be called away to assist another RN if the assigned patient's RN is with the patient.
6. PSTs must arrange their breaks with the RN and notify the RN upon their departure and return
   i. The PST's role is that of a companion and observer for safety issues.
7. Professional appearance, demeanor, and speech are the expectation at all times
8. The PST shall follow AP&P Policy #415 which includes the following:
   a. Clothing should be neat and clean
   b. Facial and tongue jewelry are not permitted
   c. Closed toe shoes must be worn in patient care areas
   d. Hair, beards, and mustaches must be trimmed and groomed
   e. Photo identification badges must be worn at all times
   f. No artificial nails or nail jewelry is permitted in patient care areas; this includes gel, gel overlays, acrylic, silk, and fiberglass.
   g. Tattoos cannot be visible

SELECT ONE OF THE FOLLOWING

☐ **I am a BLS Certified CNA/NA/MHW/RN New Grad (other clinician). I understand that I must provide care for the patient under the direct supervision of the RN. This care includes:**

1. Vital sign measurement and documentation
2. I and O measurement and documentation
3. Personal care including but not limited to: oral care, skin care, foot care, bathing, toileting, position chang linen changes, shampoo and hair care.
4. Nutritional care: feeding or assisting with meals and reporting percent eaten by patient.
5. Maintenance of safety precautions: siderails up, checking and documenting restraints per procedure, bed low and locked, and others as directed by the RN.
6. Assisting with ROM, transfers, ambulation and other activities as directed by the RN.
7. Maintenance of a neat, clean, and organized environment.
8. Immediate notification of the RN/Charge Nurse for any alarms, hazards, or safety risks to the patient.
9. Direct observation of the patient in the absence of the RN.
10. Helpfulness toward and support of family members and visitors.
11. Additional responsibilities and/or hospital related tasks may be assigned at the discretion of the RN

☐ **I am a BLS Certified hospital employee not generally assigned to patient care. I understand that I must provide direct observation of the patient and duties assigned by the RN/Charge Nurse that may include:**

1. Companionship for and conversation with the patient.
2. Maintenance of safety precautions: siderails up, bed low and locked and others not associated with direct patie care.
3. Direct observation of the patient in the absence of the RN.
4. Maintenance of a neat, clean and organized environment.
5. Helpfulness toward and support of family members and visitors.
6. Setting up and assisting pt. with meals at the discretion of the RN.
7. Immediate notification of the RN/Charge Nurse for any alarms, hazards or safety risks to the patient.
8. Assisting the RN with any mutually agreed upon physical care of the patient.
9. Additional responsibilities which may be assigned at the discretion of the RN:

I have read the PST responsibilities and selected the appropriate PST category as listed above and agree to perform my job duties in accordance with this agreement.

Signature: _____ Date: _____

Tri-City Medical Center
Oceanside, California

DELETE – follow Administrative Policy: Social Media 479

Patient Care Services

ISSUE DATE: 3/12

SUBJECT: Social Media, Nursing

REVISION DATE:

POLICY NUMBER: II.K

Department Approval:	**07/18**
Clinical Policies & Procedures Committee Approval:	**~~03/12~~08/18**
Nurse Executive Council Approval:	**~~04/12~~09/18**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~03/19~~04/19**
Professional Affairs Committee Approval:	**~~07/12~~ n/a**
Board of Directors Approval:	**07/12**

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

~~1. Social and electronic media have tremendous potential for provision of valuable information to health consumers as well as affording nurses a valuable opportunity to interface with colleagues from around the world.~~

~~2. Nurses need to be aware of the appropriate disclosure of patient related information via social media. Nurses should be mindful of professional standards, relevant state and federal laws and Tri-City Hospital District policies regarding patient privacy and confidentiality and its application to social and electronic media.~~

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

~~1. Nurses are strictly prohibited from transmitting by way of any electronic media any patient related image. In addition nurses are restricted from transmitting any information that may be reasonably anticipated to violate patients' rights to confidentiality or privacy, or otherwise degrade or embarrass the patient.~~

~~2. Nurses shall:~~

~~a. Recognize that they have an ethical and legal obligation to maintain patient privacy and confidentiality at all times.~~

~~b. Maintain professional boundaries in the use of electronic media. Use caution when having online social contact with patients or former patients. Online contact blurs the distinction between professional and personal relationships.~~

~~c. Comply with Tri City Hospital District policies regarding employer owned computers, camera, and other electronic devices, and use of personal devices in the workplace.~~

~~d. Promptly report any individual breach of confidentiality or privacy to Risk, Regulatory or your manager.~~

~~3. Nurse shall not:~~

~~a. Share, post or otherwise disseminate any information or images about a patient or information gained in the nurse/patient relationship with anyone unless there is a patient care related need to disclose the information or other legal obligation to do so.~~

~~b. Identify patient by name or post or publish information that may lead to the identification of a patient. Limiting access to posting through privacy settings is not sufficient to ensure privacy.~~

~~c. Refer to patients in a disparaging manner, even if the patient is not identified.~~

~~d. Take photos or videos of patients on personal devices, including cell phones. Hospital Administrative policy #372 must be followed when taking photographs or videos of patients for treatment or other legitimate purpose using employer provided devices.~~

e. Make disparaging remarks about employers or co-workers. Do not make threatening, harassing, profane, obscene, sexually explicit, racially derogatory, homophobic or other offensive comments.

f. Post content or otherwise speak on behalf of the employer unless authorized to do so and must follow all applicable policies of Tri-City Hospital District.

C. **References:**

1. www.Nursing world.org/SocialNetworking
2. www.TheAmericanNurse.org
3. ANA American Nurses Association
4. Administrative Policy # 516 – Patient Access to Protected Health Information (PHI)
5. Administrative Policy # 372 – Consent to Photograph/Videotape
6. Administrative Policy # 479- Social Media

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/93

SUBJECT: Swallowing, Food and Nutrition Considerations for Patients with Oro-Pharyngeal Dysphagia

REVISION DATE(S): 06/03, 08/05, 07/07, 05/10, 05/13 ~~POLICY NUMBER: IV.AA.2~~

Patient Care Services Content Expert ~~Department~~ Approval:	**08/16**
Clinical Policies & Procedures Committee Approval:	**~~09/16~~02/19**
Nurse Executive ~~Council~~ Committee Approval:	**~~09/16~~03/19**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/16~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~01/17~~ n/a**
Board of Directors Approval:	**01/17**

A. **POLICY:**

1. An order for thick liquids, thickened liquids, or no thin liquids shall be interpreted by Food and Nutrition Services staff as meals with no thin liquids until further clarification or orders are received from physician.
   a. When an order for no thin liquids is received, meals sent to the patient shall be without thin liquids. Thin liquids are defined as: water, coffee, tea, iced tea, milk, all fruit juices (~~except nectars~~), and broth, broth-based soups, soft drinks, Boost, hot chocolate, **ice cream, jello** and milkshakes.
   b. Thickened milk and thickened juices are available and may be added to the menu.
   c. Thick liquids shall be offered, **including nectar thick liquids, honey thick liquids and pudding thick liquids as determined by speech pathology recommendations**~~. These include nectar, vegetable juices, blenderized or thick cream soups, eggnog, and other pre-thickened liquids. Buttermilk shall be sent if requested~~.
   d. Foods of mixed consistencies where one consistency is thin liquid (i.e. fruit cocktail, dry cereal with milk, vegetable soup, and pineapple chunks) shall not be included unless otherwise ordered by the physician.
   e. In cases when speech therapy is involved in the patient's care, the speech pathologist may assess the patient's tolerance of liquids and may consult with the dietician, as appropriate.
      i. Recommendations for changes to diet will be made to the physician.
   f. The dietitian shall assess the patient's status per routine assessment and evaluation. The dietitian shall update the diet order in the electronic health record as appropriate.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 07/80 **SUBJECT:** Employment of Relatives

REVISION DATE(S): 03/92, 11/94, 10/97, 11/00, 03/03, 07/05, 08/12 **POLICY NUMBER:** 8610-406

Administrative Human Resources Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~08/15~~03/19**
~~Human Resources Committee Approval Date(s):~~	**~~08/15~~**
Administrative Policies & Procedures Committee Approval:	**03/19**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**04/19**
Professional Affairs Approval:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**08/15**

A. **PURPOSE:**

1. To define guidelines for employment of related individuals who may be employed by the District at the same time.

B. **DEFINITION(S):**

1. **Relative or Related:** ~~"Relative" or "related" for purposes of this Policy is defined as:~~ a spouse, parent, brother, sister, legal guardian, child, stepchild, aunt, uncle, niece, nephew, first cousin, grandparent, grandchild, mother-, father-, brother- or sister- in-laws, or any person involved in a legally binding relationship or guardianship with the employee, and/or residing in the home of the employee.
2. ~~"~~Supervisor,~~"~~ ~~"~~Supervision,~~"~~ ~~"~~Supervisory Role~~"~~: ~~for the purpose of this Policy means those~~ individuals holding the following positions: Member of the Board of Directors, **Chief Executive Officer** (CEO), **Chief ~~Organizational~~Operating Officer** (COO), **/Chief Nurse Executive** (CNE), Vice President, Director, Manager, Supervisor, or Lead.
3. ~~"~~Official~~"~~: is defined as the CEO and a member of the Board of Directors.
4. **Grandfather Clause: A grandfather clause allows the current status of something pre-existing to remain unchanged, despite a change in policy which applies in the future.**

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) will accept and consider applications for employment from relatives~~, as defined above~~. The applicant must identify any individual who is a close relative already employed by TCHD at the time he/she applies for employment. ~~(See Administrative Policy #462 Conflict of Interest)~~
2. An individual is precluded from employment with TCHD when an official has an economic interest in an individual's personal finances and those of the individual's ~~immediate family~~**relative**. A governmental decision will have an effect on this economic interest if the decision will result in the personal expenses, income assets, or liabilities of the official or the individual's ~~family~~ **relative** increasing or decreasing. ~~(Regulations of the Fair Political Practices Commission, Title 2, Division 6, California Code of Regulations, section 180703.5.)~~
3. Applicants who are relatives of a TCHD employee will not be eligible for employment with TCHD in a situation where potential problems of supervision, safety, security or morale exist including conflicts, claims of partiality in treatment at work, and personal conflicts from outside of the work environment that can be carried over into working relationships.
4. The relative cannot work within the chain of command/responsibility of the current

TCHD employee at any level.

5. The relative cannot have direct influence over a relative's pay, ~~or~~ financial data or exert influence on decisions concerning the status of employment, promotion, or compensation.
6. When a relationship exists between two employees that could present an actual or potential conflict of interest, TCHD may take appropriate action which may include reassignment, changing shifts, transfers or if necessary, possible termination.
7. Two relatives may not work in the same department or work unit, regardless of the supervisory status of either employee, or the lack of supervisory status between them.
   a. Float needs and/or patient care may supersede the above.
   b. **Grandfather Clause:** Employees who may be deemed related ~~under this Policy~~ but who were employed with TCHD prior to August 1, 2012, will be "grandfathered" such that relatives may work in the same work unit or department, so long as a supervisory relationship does not exist between the employees. **This grandfather clause will remain in effect until the employee changes status in job title, unit or department, or employment status.**
8. TCHD has the right to reassign an employee~~,~~ and limit the working relationship between the relatives, in the event that any relationship interferes with the running of a department/care unit.

~~**RELATED DOCUMENT(S):**~~

~~**9. Administrative Policy: Conflict of Interest 462**~~

D. REFERENCE(S):

~~10.~~**1. Regulations of the Fair Political Practices Commission, Title 2, Division 6, California Code of Regulations, section 180703.5.**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
PATIENT CARE

ISSUE DATE: 06/11

SUBJECT: Event ~~Incident~~ Reporting ~~– QUALITY REVIEW REPORT (QRR) RL Solutions~~

REVISION DATE(S):

POLICY NUMBER: 8610-396

~~Clinical Policies & Procedures Committee Approval:~~	~~01/15~~
~~Nurse Executive Committee Approval:~~	~~02/15~~
Administrative Patient Care Content Expert Approval:	10/18
Administrative Policies & Procedures Committee Approval:	02/19
Medical Executive Committee Approval:	03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	~~08/15~~n/a
Board of Directors Approval:	08/15

A. **PURPOSE:**

1. **Tri-City Healthcare District (TCHD)**~~he h~~Hospital has a**n** ~~electronic~~**software system** ~~early warning system~~ to track, trend, and respond to events that may have an impact, or potential impact, on patients, ~~/~~visitors, ~~/~~employees**, and or** ~~/~~medical staff. Reporting and responding to these occurrences is a **process**~~method~~ **engaged** ~~performed~~ to objectively and systematically monitor and evaluate quality and appropriateness of patient care. This ~~procedure~~ helps to identify **areas or events of concern** ~~and investigate near miss and serious incidents to insure patient safety~~ and **timely** resolve quality **and** ~~/~~risk issues on an ongoing basis**. This will improvee** ~~nhancing~~ the quality of patient care**, patient safety,** and **potentially** reduce~~ing~~ health care **costs** and ~~medical~~ liabilitie**s**~~y~~. These **reportable events**~~incidents may~~ include unusual occurrences, adverse events, **near misses,** and sentinel events.

B. **DEFINITIONS:**

1. **Adverse Event:** An occurrence that causes the death or serious disability of a patient, personnel, or visitor, and as listed in Section 1279.1~~, et seq.,~~ of the **California** Health and Safety Code. **Events listed in this section of law represent only a portion of events that should be entered into the on-line event reporting system.**
2. **Near Miss Event: an unplanned event that did not result in injury, illness, damage or death but had the potential to do so. Only a fortunate break in the chain of events prevented the event from occurring.**
3. **RL Solutions (RL): Third party vendor whose software we use for reporting unusual occurrences, near misses, adverse events, sentinel events, and patient complaints.**

~~3.~~**4. Sentinel Event:** an unexpected occurrence involving death or serious physical or psychological injury~~,~~ or the risk thereof. ~~Serious injury includes loss of limb or function.~~ The phrase "or the risk thereof" includes any process variation for which recurrence would carry a significant chance of a serious adverse outcome.

~~4.~~**5. Software System Event Reporting** ~~**Quality Review Report (QRR)/RL Solutions Incident Report (RL)**~~**:** An online system designed to collect data/information regarding events that may have an impact or potential impact on patients~~/~~, visitors~~/~~, employees~~/~~, medical staff. This **software is for, but not limited to,** ~~online electronic system includes~~ reporting of employee injuries ~~and disputes~~, patient compliments and complaints, medication errors, **clinical misadventures, and near misses** ~~and cardiopulmonary resuscitation information~~. The **event**

report~~QRR/RL is subject to all privileges~~ **is legally privileged information** and **typically** exemption from **discovery pursuant** ~~disclosure provided into~~ applicable law.

~~5.~~**6.** **Unusual Occurrence:** Any event that deviates from regular operations or standards and results in, or could have resulted in (near miss), an adverse outcome for patients**, staff,** or visitors.

~~6.~~**7.** **Workforce Member: Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.**

~~7.~~**C.** **POLICY:**

~~8.~~**1.** All **workforce** members ~~of the healthcare team and all employees of~~ **at TCHD** ~~Tri-City Healthcare District~~Medical Center are responsible for participating in the identification of **reportable** ~~incident~~**events including near miss events** ~~that should be reported by initiating a QRR/RL.~~ **and** ~~R~~reporting ~~will be done~~ via the **event reporting software**~~RL Solutions Module in the hospital intranet by any hospital employee. The incident report is called the RL Report (RL) or the Quality Review Report (QRR).~~

a. The employee who is **most closely**~~directly~~ involved~~,~~ or discovers an event **or concern,**~~/situation,~~ should complete **an event report**~~QRR/RL~~ with as much detail **about the event** as possible ~~of the incident~~.

~~9.~~**b.** Medical Staff members can initiate **an event report** ~~QRR/RL~~ by contacting the Medical Staff office **Quality Coordinator or by entering the event themselves utilizing the** ~~RL~~**event reporting software**.

~~a.~~**c.** All non-~~hospital~~ **TCHD** employees (i.e. travelers, registry, and contracted service individuals) **will**~~shall~~ report events up through their chain of command **for entry in the event reporting software.**

2. **The event report should:**

~~10.~~**a.** ~~Documentation on the QRR/RL should be t~~**Be** timely, objective, informative, and factually describe what happened **as well as**~~nd~~ any follow-up **that was done.** ~~Subjective comments should not be made~~

~~a. Never confidentiality this document should not be referenced or filed in the medical record to maintain quality assurance legal protections,~~

b. **Not be**~~,~~ left unattended, copied, shared with **a** patient or visitor, filed or referenced in the employee's personnel file, or removed from premises **without the express consent of either the Risk or Legal Department.**

c. ~~Only employees receive the QRR/RL. The QRR/RL should n~~**N**ot be a part of the medical record~~,~~ and shall not **be referenced in the medical record at any time.**~~be printed.~~ The **event**~~incident~~ **may**~~ay~~ be recorded in the medical record as appropriate.

~~11. Unusual occurrences, sentinel events and other adverse events will be immediately reported to Risk Management and the appropriate administrative office(s.~~

3. **Events that should be immediately brought to the attention of the Risk Manager and or House Supervisor as necessary include**~~ing by~~ **but are not limited to:**

~~12.~~**a.** **Sentinel events and other high level concerns**~~events~~.

i. If the event occurs after office hours **or on weekends**, the Administrator on-call will determine **whether or not to contact** ~~emergency contact of~~ Risk Management.

ii. **Entry**~~The completion~~ of the ~~QRR/~~**event report**~~RL~~ should not delay or interfere with appropriate **clinical care or intervention**~~follow-through~~.

~~13.~~**iii.** **Department leadership**~~Risk Management~~ will perform an investigation on any occurrence that is identified as a potential risk. **Risk Management will assist with complex investigations including root cause analyses.** Documentation of this follow-up will be **entered into the event reporting software** ~~RL.made on QRR/RL~~

b. Any events involving actual or alleged **criminal activity including, but not limited to,** abuse, neglect, battery, assault, sexual misconduct, or mistreatment of patient or staff ~~should be reported on the QRR/RL and sent to Risk Management along with a call to Risk Management immediately by the person preparing the QRR/RL for investigation and follow-up~~.
   i. **A police report should also be filed as appropriate.**
   ii. Risk Management **or their /**designee will convene a team of individuals as **necessary**~~indicated~~ to investigate~~ and ensure appropriate investigation,~~**, take action** and follow-up.
      ~~14.~~1) **Mandatory** reporting **will be done in collaboration with the Regulatory ~~Compliance~~ Department**,. ~~Refer to the following Administrative and Patient Care Services Policies in the Reference Section:~~

~~a. Administrative Policy: Assault and Battery Reporting Process, 8610-241~~
~~b. Administrative Policy: Assault Victims/Domestic Violence Reporting Requirements, 8610-310~~
~~c. Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families, 8610-275~~
~~d. Administrative Policy: Mandatory Reporting Requirements, 8610-236~~
~~e. Administrative Policy: Reporting Suspected Child Abuse/Neglect, 8610-308~~
~~f. Administrative Policy: Reporting Suspected Dependent Adult/Elder Abuse/Neglect, 8610-309~~

~~15.~~4. When ~~such~~ an event occurs, the **workforce member**~~patient care provider or hospital employee~~ **will**~~shall do the following~~:
   a. Perform the necessary interventions to support **and optimize** the patient's clinical condition
   ~~b. Perform the necessary interventions to contain the risks from~~to ~~others~~
   b. Notify the patient's attending physician.
      ~~c.~~**i.** Notification of **the** physician and any new orders as a result of **an event**~~occurrence~~ will be documented ~~by the clinician~~ in the patient's **electronic health record (EHR)**~~medical record~~
   ~~d.~~**c.** Preserve any information related to the event including physical evidence
   ~~e.~~**d.** ~~Preservation of the information includes the d~~**D**ocumentation ~~the~~**of** facts regarding the event **both in event reporting system** ~~on a QRR/RL~~ and the **EHR**~~Medical Record~~ as indicated
   ~~f. Notify immediate supervisor of the event and Risk Management of any significant, or sentinel events.~~

~~16. The QRR/RL will help identify patterns or trends and/or significant quality of care issues, which in turn, provide a focus for performance improvement, patient safety, and risk management.~~

~~17.~~5. All **event reports** ~~QRR/RLs~~ **are automatically routed to the leadership of the area in which the event occurred and simultaneously**~~go~~ to Risk Management for assessment. Risk Management routes **the file to any additional appropriate recipients who did not receive the file via automated routing**~~the QRR/RL to appropriate Director/Manager. QRR/RLs involving physicians go to Medical Staff Office.~~
   a. If the Medical Staff **Quality Coordinator**~~Office Manager~~ believes **that**~~a summary of~~ the ~~incident~~**event** requires peer review or other Medical Staff **action**~~action~~, the **Coordinator** ~~Manager~~ may share a summary of the ~~incident~~**event**, but not the **event report itself**~~QRR/RL~~, with the appropriate Medical Staff officer, committee, or department in accordance with Ongoing Professional Practice Evaluation/Peer Review Process 8710-509.

D. PROCEDURE:

~~18.~~1. **Log into the software on the ~~hospital~~TCHD Intranet to report an event.**
   a. **Enter employee number as the Username and "rl" as the Password.**

~~b. Action steps to complete a QRR/RL~~
~~c. Enter RL Solutions from the TCMC Intranet~~
~~d. Log in to RL Solutions with your employee #. Your password is "rl" (lower case letters)~~
~~e. Select the icon for the category/type of incident or occurrence. The icons include: (See RL Solutions Icon Wall Sample)~~
~~i. Airway Management~~
~~ii. AMA/Elopement~~
~~iii. Patient/Visitor Complaints~~
~~iv. Diagnosis/Treatment~~
~~v. Care/Service Coordination~~
~~vi. Diagnostic Test~~
~~vii. Fall Event~~
~~viii. Infection Control/Surgical Site Infection~~
~~ix. Lab Specimen/Test~~
~~x. Line Tube/Vascular~~
~~xi. Maternal/Childbirth~~
~~xii. Medication Event~~
~~xiii. Adverse Drug Reaction~~
~~xiv. Safety/Security/Conduct~~
~~xv. Skin/Tissue~~
~~xvi. Surgery/Procedure~~
~~xvii. Privacy~~
~~xviii. Blood/Blood Products~~
~~xix. Employee/Affiliate Event~~
~~xx. Environment of Care~~
~~xxi. Equipment and Product~~
~~xxii. ID/Documentation/Consent~~
~~xxiii. Professional Conduct~~
~~xxiv. Restraint/Supportive Device~~

b. Complete all ~~the~~ mandatory information fields. The mandatory fields have a green asterisk **next to them**.

~~f.~~**c.** Additional **documents**~~attachments~~ may be ~~added to this form.~~ **attached/uploaded to the file in a section labeled attachments found on every reporting template.**

~~g.~~**d.** **After completing all required fields, left click** ~~P~~**press** ~~the~~ **green** "Submit Button" **in the lower right hand corner of the template. Staff**~~You~~ will receive a **file** number which has been assigned to the ~~incident~~**event**. ~~This is the RL number.~~

~~10.~~**2. File managers' responsibilities**~~Action Steps: Responding to QRR/RLs: (See Reporting of and Responding to Unusual Occurrences)~~**:**

a. **The** Director **or designated** ~~/Manager~~ **manager** must acknowledge receipt of the **file** ~~e~~ ~~QRR/RL~~ and follow-up ~~with these~~ within 72 hours of receipt ~~of the QRR/RL~~. **The file should be closed out within 7 days of entry with the exception of events requiring complex or extensive investigation.**

3. Risk Management responsibilities:

~~b.~~**a.** Risk Management will **coordinate**~~take the~~ necessary actions ~~(report to regulatory body, insurance carriers, etc.)~~ after the completion of the investigation.

~~c.~~**b.** Risk Management **may**~~shall~~ initiate a ~~Legal H~~**h**old on the **billing associated with an adverse clinical event**~~encounter and alert the appropriate departments (i.e. Information Technology, Medical Records, Patient Financial Services, etc.)~~**until such time as a determination may be made as to whether or not the patient and or their insurance should be billed for the care at issue. Events that trigger a billing hold must be resolved within 45 days for timely action by financial services.**

~~d.~~c. Risk Management is responsible for forwarding physician-specific events to the Medical Staff o~~O~~ffice. The Medical Staff office determines **whether or not**~~if~~ the event **will be subject to one or more means of formal review**~~is to be peer reviewed~~.

~~e. Risk Management will contact the appropriate department for information purposes or follow up.~~

~~f.~~d. **Event report** ~~Information~~**data** will be **analyzed**~~trended~~ and monitored to identify patterns or trends **in order to optimize**~~that have or may jeopardize~~ patient~~/visitor~~ safety **and the delivery of consistently high quality patient care. Proper analysis will result in**~~Variables will be analyzed and~~ corrective action instituted to reduce the probability of occurrence or re~~e~~occurrence~~, and improve performance~~. Employees and medical staff are encouraged to ~~identify opportunities for improvement in the QRR/RL review process.~~**recommend improvements related to events reported in the software.**

~~g.~~e. If Risk Management determines an event require~~s~~d a Root Cause Analysis (RCA), Risk Management will ~~collaborate with the Director of Performance Improvement to~~ convene a team **for that purpose**.~~-~~ The RCA **process** will **include thorough event investigation, group analysis of the event, and creation of an action plan to reduce risk and measure progress.** ~~incorporate reduction strategies and measurement of process and systems improvements to reduce risk.~~

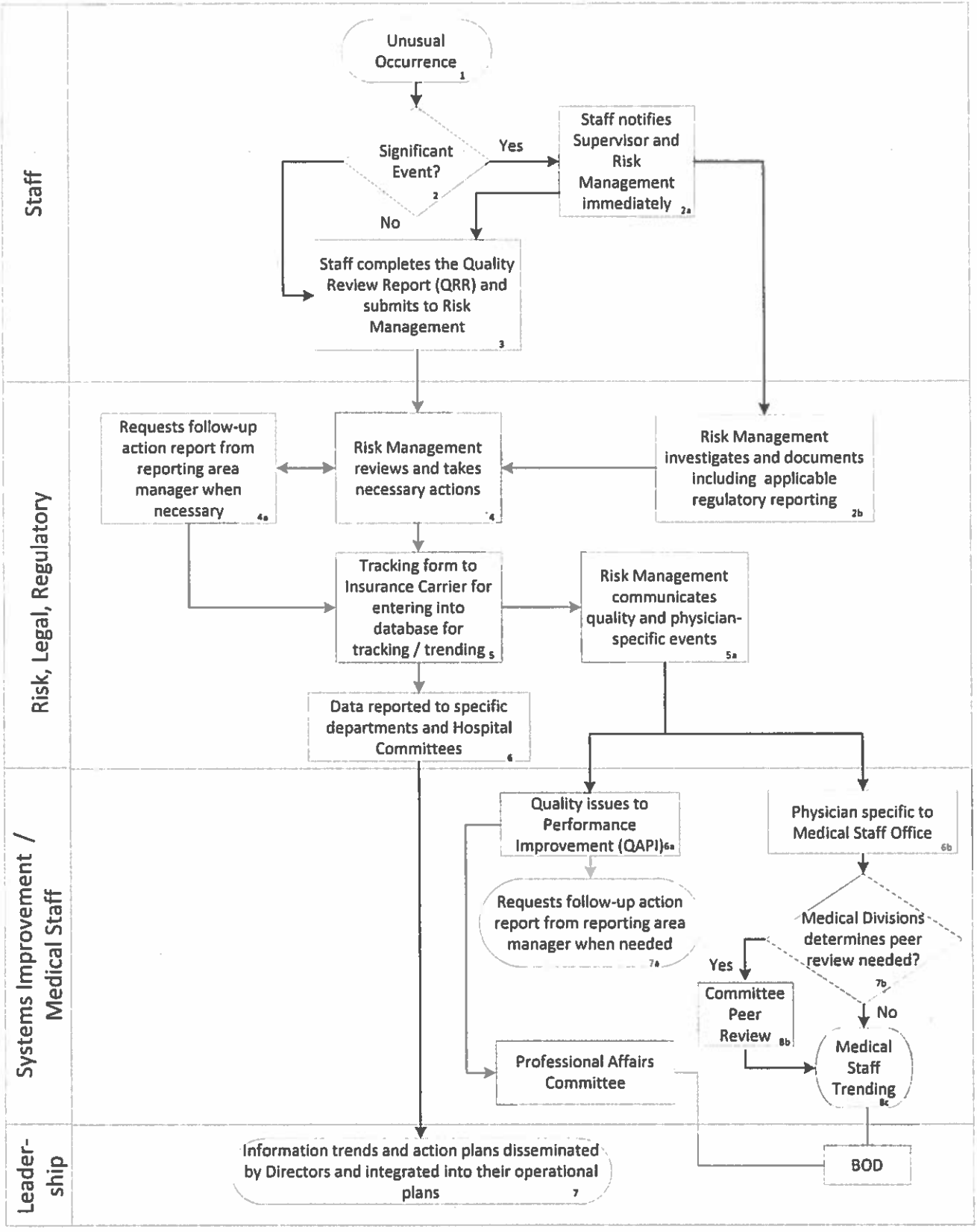
~~C.~~E. FORMS/~~RELATED POLICIES~~ DOCUMENT(S):

~~1.~~ ~~RL Solutions Icon Wall~~
~~2.~~1. Reporting of and Responding to Unusual Occurrences
~~3.~~2. Administrative Policy: Assault and Battery Reporting Process, 8610-241
~~4.~~3. ~~Administrative~~ **Patient Care Services** Policy: Assault Victims/Domestic Violence Reporting Requirements~~, 8610-310~~
~~5.~~4. Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families, 8610-275
~~6.~~5. Administrative Policy: Mandatory Reporting Requirements, 8610-236
~~7.~~6. ~~Administrative~~ **Patient Care Services** Policy: Reporting Suspected Child Abuse/Neglect~~, 8610-308~~
7. ~~Administrative~~ **Patient Care Services** Policy: Reporting Suspected Dependent Adult/Elder Abuse/Neglect~~, 8610-309~~
8. **Patient Care Services Policy: Patient Complaints and Grievances~~, 8610-318~~**
9. **Medical Staff Policy:** Ongoing Professional Practice Evaluation/Peer Review Process 8710-509

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

1. California Evidence Codes ~~95~~41156
2. **The Patient Safety and Quality Improvement Act of 2005**
3. **California Health and Safety Code 1279.1**
~~1.~~4. California Hospital Association Consent Manual (201~~5~~7)

Reporting of and Responding to Unusual Occurrences



Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
DISTRICT OPERATIONS~~COMPLIANCE~~

ISSUE DATE: NEW

SUBJECT: Medical Procedures and Interrogations Requested by Law Enforcement

REVISION DATE(S):

POLICY NUMBER: ~~8750-595~~ 8610-211

Department Approval: ~~06/17~~07/17
Administrative Policies ~~and~~ & Procedures Committee Approval: ~~07/17~~07/18
~~**Organizational Compliance Committee Approval:** 08/17~~
Medical Executive Committee Approval: ~~10/17~~02/19
~~**Audit, Compliance and Ethics Committee Approval:** n/a~~
Administration Approval: ~~03/19~~04/19
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. PURPOSE:

1. To ensure Hospital compliance with State and Federal law while maintaining patients' privacy rights under HIPAA, CA Constitution, and the Fourth Amendment.

B. DEFINITION(S):

1. HIPAA – Health Insurance Portability and Accountability Act (HIPAA) of 1996, privacy regulations published under the Congress of the United States.
2. Fourth Amendment – Fourth Amendment to the United States Constitution, Federal search and seizure law that protects citizens from unreasonable searches by law enforcement absent specific exceptions.
3. Law enforcement/officer – includes Oceanside, Vista, or Carlsbad Police Officers, Sheriff's Department officers, Detectives, Federal Bureau Investigation, Homeland Security, United States Marshal or other applicable state or federal agents.
4. According to CA Vehicle Code Section 23612 – a code of California Law, law enforcement may perform or request tests to detect the presence of alcohol or drugs when suspected of driving under the influence according to this Code Section and the "implied consent law". Essentially, the motor vehicle operator "impliedly" gives consent to submit to a blood or breath test. This law is considered unconstitutional in accordance with the US Supreme Court. *Missouri v. McNeely* (2013) 569 U.S. 141. Thus, a patient must give clear, willing and voluntary consent. If the person/patient is uncooperative or indecisive regarding his/her consent, the officer must obtain a search warrant or court order. (The CA Implied Consent law is currently under review by CA Supreme Court)

C. POLICY:

1. A law enforcement officer may bring a person to a hospital and request an evaluation of that person's medical condition and/or request that the hospital perform medical procedures on the person. The person may be a suspect, victim, witness or bystander.
2. In general, physicians and hospital personnel are not required by law to perform medical evaluations or procedures at the request of law enforcement officers ~~except for a narrow list of instances described in paragraph 4, below~~.
3. If a state or federal law requires a health care provider to report to law enforcement, then patient-identifiable information may be disclosed to the extent necessary to comply with the

reporting law. Thus hospital, physician(s) and others may, without violating health information confidentiality laws, report child abuse, elder abuse, rape, suspicious injuries, etc., to law enforcement officers or agencies. *See* 45 C.F.R. 164.512, Cal. Pen. Code §§ 11164-11174, 11160-11163.6; and Welf. & Inst. Code §§ 15630-15632. If there are questions regarding the law, please contact the legal department.

a. Only the minimum information necessary to fulfill the requirement of the reporting law may be disclosed. There are instances where California law applies and limits the disclosures that would otherwise be permissible under HIPAA.

4. Physicians and other hospital personnel should not perform medical evaluations or procedures request by law enforcement officers except in the following circumstances:
   a. The patient or legal representative consents;
   b. A medical emergency exists and the patient does not object to the procedure;
   c. The officer requests a blood test pursuant to Vehicle Code Section 23612, the request follows the patient's lawful arrest, **BUT the patient must affirmatively consent.** If the patient does not consent, a warrant is necessary. If the patient is unconscious or otherwise unable to consent, **a valid search warrant or court order is required;**
   d. The officer requests a noninvasive medical evaluation to determine if it is medically safe to incarcerate the person; or
   e. The officer requests the medical evaluation or procedure to be performed pursuant to a valid search warrant and/or court order with judge's signature.
5. If the patient (or legally authorized representative) consents, a physician and/or hospital personnel may perform the medical evaluations or procedures requested by law enforcement. When indicated, the hospital should verify that the person has given informed consent.
6. The California Legislature has stated that adults housed in state prison have the fundamental right to control decisions relating to their own health care. This includes the right to give informed consent.
7. A law enforcement officer may bring an arrested person to the hospital for a limited physical examination to determine if it is medically safe to incarcerate the arrestee. If the patient is brought to ~~**the facility**~~**TCMC**~~an ED~~ for pre-jail clearance, the hospital performs a medical screening examination. There is no legal requirement for the hospital to communicate any information to law enforcement about the patient. **However, the physician may, with the patient's consent, disclose to law enforcement whether the patient is medically cleared and fit for booking.**~~The conclusion as to whether or not it is medically contraindicated to incarcerate the arrestee may be disclosed to law enforcement officers.~~
8. Law enforcement officers may conduct constitutionally permissible searches pursuant to a valid search warrant. The procedures may be performed only if the warrant:
   a. States a finding of probable cause and
   b. Specifically describes the person and the procedures to be performed.
9. Law enforcement may request to interrogate a patient in a hospital. If the officer has a court order or a signed search warrant, the hospital should generally permit the officer access to the patient so long as the patient is stable. In addition, if the officer is responding to a crime or an emergency on the facility premises, the hospital also should generally permit the officer access to the patient/s. If the hospital has concerns or questions, contact the legal department.
10. If a competent adult consents to cooperate with law enforcement officers, that person's desire should be respected. A patient who indicates a desire to cooperate with law enforcement should be fully informed by the healthcare provider of any possible adverse medical consequences, and the patient's consent, in light of his or her receipt of such information, should be documented in the medical record as is the Hospital's standard policy before commencing any medical procedure or treatment.
11. Hospitals are generally under no duty to inform law enforcement upon the discharge of a patient, with the exceptions noted which follow. Information about discharge is protected health information by both state confidentiality laws and HIPAA and thus must meet legal requirements

for release. Situations which disclosure of discharge information to law enforcement would appear to be permissible are as follows:

a. When a patient communicates a serious threat of physical violence to a licensed psychotherapist, or other healthcare provider, and it is appropriate that law enforcement be contacted in order to protect the threatened person/s after consulting with the legal department.
b. Upon discharge or release of a patient who was detained or apprehended for examination of his or her mental condition and who had a weapons confiscated by law enforcement.
c. Upon the escape/elopement, disappearance, release, or transfer of specified mental health patients,
d. When a patient is detained for 72-hour evaluation and treatment, and the peace officer who detained the patient did the following:
    i. Requested notification of discharge when he/she brought the patient in; **AND**
    ii. Certified in writing that either (i) the patient was referred to the facility under circumstances that support the filing of criminal charges; or (ii) that a weapon was confiscated pursuant to Welfare and Institutions Code section 8102,
    iii. Only the patient's name, address, date of admission for 72 hour evaluation, date of certification for intensive treatment (if applicable), and date of release may be disclosed.

12. For other circumstances, please consult with the Legal Department, and if necessary the Chief Compliance and Privacy Officer before providing any patient requested information or allowing interrogations by law enforcement officers and consult with Risk Management before performing medical procedures.
13. If an "in-custody" patient or patient under arrest presents ~~in the ED~~**to ~~the facility~~TCMC**, ~~ED~~ medical staff should contact the Security Officer. The Lead Security Officer will make timely contact with any law enforcement and if necessary, conduct a forensic training in-service. The designated security officer is responsible for evaluating the level of security restraint being used to control the "in custody" patient.
    a. For the safety, security, and welfare of all staff, visitors, and patients, the designated Security Officer will monitor the "in custody" patient during their stay at the Medical Center.
    b. It is not the responsibility of medical staff to determine the type of restraints needed; however, if any restraints are interfering with medical treatment, attending medical staff must inform the Security Department and the designated security officer will assist in relocating the device to an alternate location on the patient.
    c. *See* Administrative Policy: 219 Security Precautions Associated with Incoming In Custody Patients **and ~~Patient Care Services Policy: VI.B.2~~**.
14. Requests for any hospital video surveillance by law enforcement should be referred to the Legal Department and notify Risk Management.

D. RELATED DOCUMENT(S):

1. ~~Administrative~~ **Patient Care Services** Policy: ~~308~~ Reporting Suspected Child Abuse and Neglect
2. ~~Administrative~~ **Patient Care Services** Policy: ~~309~~ Reporting Suspected Dependent Adult Elder Abuse Neglect
3. ~~Administrative~~ **Patient Care Services** Policy: ~~310~~ Assault Victims Domestic Violence Report Requirement
4. Administrative **Patient Care** Policy: ~~372~~ Consent to Photograph and Videotape **8610-372**
5. ~~Administrative~~ **Security** Policy: ~~219~~ Security Precautions Associated with Incoming In Custody Patients **219**
6. ~~5.~~ **Patient Care Services Policy: Justice Involved Patient**

E. REFERENCE(S):

1. Health Insurance Portability and Accountability Act (HIPAA) of 1996
2. Fourth Amendment to the United States Constitution
3. CHA Consent Manual 2018, Chapter 9, pp. 9.3-9.5
4. CA Vehicle Code Section 23612(a)
5. *Missouri v. McNeely* (2013) 569 U.S. 141
6. 68 Ops.Cal.Atty.Gen. 189 (1985)
7. Welfare and Institutions Code §§ 8102, 15630-15632
8. 45 C.F.R. 164.512
9. Cal. Pen. Code §§ 11164-11174, 11160-11163.6

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: NEW **SUBJECT:** Recyclable Waste

REVISION DATE(S): **POLICY NUMBER:** 8610-209

Administrative District Operations Content Expert Approval:	**10/18**
Administrative Policies & Procedures Committee Approval:	**02/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**04/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. In order to ensure that Tri-City Healthcare District **(TCHD)** maintains proper hygiene and infection control practices for all staff and visitors in all facilities with recyclable waste products and containers.

B. **DEFINITIONS:**

1. Recyclable Waste:— ~~i~~Includes paper and cardboard; non-contaminated plastics or metals; aluminum cans or glass bottles;
2. Waste Sharps:— ~~a~~All objects and materials are closely linked with health care activities and pose a risk of injury and infection due to their propensity of puncturing the skin.
3. Biodegradable Waste:— ~~w~~Waste comprises of left-over food; or garden type waste that can be composted.

C. **POLICY:**

1. It is the policy of ~~the Tri-City Healthcare District~~**TCHD** to ensure waste materials are reduced, reused, repurposed, recycled or disposed of properly, in order to protect the public health and environment. The TCHD Health Care Waste Management (HCWM) program is an integral part of the hospital hygiene and infection control. TCHD has incorporated proper procedures to minimize the overall risks associated with staff or visitors to the hospital of coming into direct contact with infected waste or sharp items located in waste containers.
2. All Recyclable or Biodegradable Waste items are considered the property of TCHD and not to be confiscated by staff, visitors or guests to any TCHD facility to be utilized for their own personal use.
3. All staff, visitors or guests to any TCHD facility are not to retrieve or scavenge for any Recyclable or Biodegradable Waste item(s) from any receptacle or container on the hospital premises.
   a. ~~Therefore;~~ Any TCHD staff member observed scavenging through any recyclable or waste containers or removing recyclable or biodegradable TCHD property **for their own personal use** will be subject to disciplinary actions.
4. All recyclable or waste receptacles will be managed by and are to only be emptied or changed out by TCHD EVS staff, Food and Nutrition staff or contracted services into approved waste receiving containers.
5. TCHD EVS staff, Food and Nutrition staff or contracted services that handle or empty any recyclable or waste receptacles are to follow hospital hand hygiene procedures to prevent any risks to themselves, staff or visitors to the facility.

6. ~~Tri-City Health Care District, as a Special District of the State of California, is held to the California Constitution; specifically Article XVI, section 6 which prohibits making "gifts" of public funds: "The Legislature shall have no power . . . to make any gift or authorize the making of any gift, of any public money or thing of value to any individual, municipal or other corporation whatever.~~

D. RELATED DOCUMENT(S):

~~1. Administrative Policy 500 – Code of Conduct~~

1. Infection Control **Policy:** ~~IC. 8 –~~ Hand Hygiene **IC.8**
2. **Tri-City Healthcare District Code of Conduct**

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

~~1. California Constitution, Article XVI, Sec. 6~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 06/10 **SUBJECT:** Social Media

REVISION DATE(S): **POLICY NUMBER:** 8610-479

Administrative Human Resources ~~Department~~ Content Expert Approval:	~~09/1407/18~~12/18
Administrative Policies ~~and~~& Procedures Committee Approval:	01/19
Medical Executive Committee Approval:	02/19
~~Organizational Compliance Committee Approval:~~	
~~Human Resources Committee Approval:~~	
Administration Approval:	~~03/19~~04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/14

A. **PURPOSE:**

1. The purpose of this policy is to ~~provide Tri-City Healthcare District (TCHD) employees with guidelines for participation in social media, which includes texting, in which the employee's TCHD affiliation is known, identified, or presumed.~~ensure patients', ~~W~~workforce ~~M~~member~~'~~s', and Tri-City Healthcare District's (TCHD) Proprietary, private and confidential information is protected from disclosure, whether inadvertent or otherwise.
2. This policy is to prevent the use of social media to discriminate, harass or engage in other inappropriate conduct by and/or towards patients and ~~W~~workforce ~~M~~members.
3. This policy applies to ~~W~~workforce ~~M~~members using social media while at TCHD, when away from TCHD, and when the ~~W~~workforce ~~M~~member's TCHD affiliation is identified, known, or presumed.
4. This policy is not intended to restrict ~~W~~workforce ~~M~~members' legitimate right to comment on TCHD or its policies, but rather provide professional guidelines for participation in ~~S~~social ~~M~~sedia.

B. **DEFINITION(S):**

1. Social Media: websites and/or applications that enable users to create and share content or to participate in social networking.
   a. Social ~~M~~media examples include, but are not limited to, text messaging, blogs, podcasts, discussion forums, online collaborative information, publishing systems accessible to internal and external audiences, Wikis, Rich Site Summary feeds, Syndication feeds, video sharing, and applications such as YouTube, MySpace, Facebook, LinkedIn, YahooIGroups, Twitter, Snapchat and Instagram.
2. Workforce Member: ~~e~~Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees~~,~~ and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.

~~1. Blog – Short for "Web log," a site that allows an individual or group of individuals to share a running log of events and personal insights with online audiences.~~

~~2. Electronic Media: Non-computing devices, i.e. floppy diskettes, flash memory drives, CDs DVDs, tapes, hard disks, internal memory, and any other interchangeable, reusable, and/or portable electronic storage media (1) on which electronic information is stored, or (2) which are used to move data among computing systems/devices.~~

~~3. Tri-City Medical Center Information: Information in any form or media that is created by or on behalf of TCHD in the course and scope of its business, regardless of whether that information~~

~~is maintained or stored by TCHD and others on TCHD's behalf. Examples of TCHD information include, but are not limited to, patient and member records, personnel records, financial information, company competitive information, TCHD developed intellectual property, and business e-mail messages.~~

4. ~~Patient Identifiable Information (PII) – Any individually identifiable information regarding a patient of TCHD collected, received, created, transmitted, or maintained in connection with his/her status as a patient. PII includes, but is not limited to, information about a patient's physical or mental health, rare diseases or medical conditions, the receipt of health care, or payment for that care; patient records, pictures, photographs, audiotapes or other images of the patient, name, address, Social Security Number, account number, security code, information from or about transactions, driver's license number, financial or credit account numbers, phone numbers, ISP and Internet domain addresses, and other personal identifiers.~~
5. ~~Podcast – A collection of digital media files distributed over the Internet, often using syndication feeds, for playback on portable media players and personal computers.~~
6. ~~Protected Employee Information (PEI) – Information collected, received, created, transmitted, or maintained by TCHD in connection with a person's status as an employee, including but not limited to, Social Security number, address, telephone number, driver's license number, information about an employee's physical or mental health, emergency contact information, insurance information, disciplinary actions against employees, and complaints filed by employees or against employees.~~
7. ~~Protected Health Information (PHI) – Individually identifiable information (oral, written or electronic) about a patient's physical or mental health, the receipt of health care, or payment for that care. PHI includes individually identifiable member/patient payment, insurance information, or demographic information as defined by HIPAA.~~
8. ~~RSS feeds or Syndication feeds – A family of different formats used to publish updated content such as blog entries, news headlines or podcasts and "feed" this information to subscribers via email or by an RSS reader. This enables users to keep up with their favorite Web sites in an automated manner that's easier than checking them manually (known colloquially as "really simple syndication").~~
9. ~~Social media – Includes but are not limited to text messaging, blogs, podcasts, discussion forums, on-line collaborative information and publishing systems that are accessible to internal and external audiences, such as Wikis, video sharing, such as YouTube, and social networks like MySpace, Facebook, Yahoo!Groups, and Twitter,~~ **Snapchat and Instagram.**
10. ~~Tri-City Medical Center Proprietary and Confidential Information Information and physical material not generally known or available outside TCHD and information and physical material entrusted to TCHD in confidence by third parties. Examples include, but are not limited to, patient and member records, personnel records, financial information, company competitive information, TCHD developed intellectual property, business e-mail messages, and information about TCHD's affiliates, doctors, vendors or suppliers.~~
11. ~~Wiki – allows users to create, edit, and link Web pages easily; often used to create collaborative Web sites and to power community Web sites, including Wikipedia.~~

C. **POLICY:**

1. ~~To ensure that patients' private and confidential medical information is protected from disclosure by employees whether inadvertent or otherwise.~~
2. ~~To ensure that TCHD's Proprietary and Confidential Information is protected from disclosure by employees, whether inadvertent or otherwise.~~
3. ~~To ensure that employees' private and confidential information is protected from disclosure by employees, whether inadvertent or otherwise.~~
4. ~~To prevent the use of social media to discriminate, sexually harass or engage in other inappropriate conduct by and toward TCHD employees.~~
5. ~~This policy applies to employees who use the following including but not limited to:~~

~~a. Social media websites, including but not limited to MySpace, Facebook, Yahoo!Groups, Twitter, Podcasts, and YouTube;~~ **Snapchat and Instagram**

~~b. Blogs (whether internal or external to TCHD); and~~
~~Wikis such as Wikipedia and another site where text can be posted.~~

1. **Workforce ~~M~~members shall recognize their ethical and legal obligation to maintain patients', ~~W~~workforce ~~M~~member's' and TCHD's Proprietary and Confidential information private and confidential at all times.**
   - **a. Protected Health Information (PHI):**
     - **i. TCHD has a legal obligation to protect patients' PHI from disclosure. ~~W~~workforce ~~M~~members are strictly prohibited from transmitting any PHI, images, or information that may be reasonably anticipated to violate patients' rights to confidentiality or privacy, and/or otherwise degrade or embarrass the patient by way of any ~~S~~social ~~M~~media.**
     - **ii. Disclosure of PHI is subject to discipline up to and including termination of employment per Administrative Human Resources Policies: ~~455~~ Confidentiality 8610-455 and ~~609~~ Administrative Information Technology Policy: Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information 8610-609.**
     - **iii. Refer to Administrative Patient Care Policy: ~~372~~ Consent to Photograph/Videotape 8610-372 when taking photographs or videos of patients for treatment or other legitimate purpose using employer provided devices.**
   - **b. Workforce Member's Information:**
     - **i. Workforce ~~M~~members have a privacy interest in their personnel files and any information contained therein. This interest extends to any information collected, received, created, transmitted, or maintained by TCHD in connection with a ~~W~~workforce ~~M~~member including, but not limited to ~~S~~social ~~S~~security number, address, telephone number, driver's license number, physical health, mental health, disciplinary actions, and complaints filed by or against ~~W~~workforce ~~M~~members.**
     - **ii. Workforce ~~M~~members accessing or utilizing ~~S~~social ~~M~~media, whether for TCHD business or for personal reasons, may not disclose such private and confidential information and is subject to discipline up to and including termination of employment.**
   - **c. TCHD Proprietary and Confidential Information:**
     - **i. TCHD has an interest in protecting its information and physical material not generally known or available outside, as well as information and physical material entrusted to TCHD from disclosure to third parties.**
     - **ii. Proprietary and Confidential Information includes, but are not limited to, patient and member records, personnel records, financial information, company competitive information, TCHD developed intellectual property, business e-mail messages, and information about TCHD's affiliates, doctors, vendors and/or suppliers.**
     - **iii. Although neither TCHD, the patient, nor the ~~W~~workforce ~~M~~member may not be identifiable by name, references to information about TCHD, the patient and/or the ~~W~~workforce ~~M~~member may allow the reader or viewer to the identify TCHD. Such inadvertent disclosure, although not intentional, is a violation of this policy and may be a violation of law including the Health Insurance Portability and Accountability Act (HIPAA).**
     - **iv. TCHD Proprietary and Confidential Information remains the property of TCHD and unauthorized disclosure, whether in ~~S~~social ~~M~~media accessed or utilized for TCHD business or for personal reasons, is subject to discipline up to and including termination of employment.**

2. Workforce ~~M~~members shall maintain the utmost professionalism in the use of ~~S~~social ~~M~~media.
   a. Use caution when having electronic contact with patients, ~~W~~workforce ~~M~~member's, or affiliates. Online contact blurs the distinction between professional and personal relationships.
   b. Workforce ~~M~~members should not use ~~S~~social ~~M~~media to communicate inappropriately, discriminate against, or harass patients or other ~~W~~workforce ~~M~~members. Such inappropriate use of ~~S~~social ~~M~~media, even if carried out on personal ~~S~~social ~~M~~media applications, may subject the ~~W~~workforce ~~M~~member to disciplinary action up to and including termination of employment.
   c. Threatening, harassment, profane, obscene, sexually explicit, racially derogatory, homophobic, and/or other offensive comments will not be tolerated. Refer to Administrative Human Resources Policy: ~~403~~-Discrimination, Harassment, and Retaliation Prevention 8610-403.
   d. Workforce ~~M~~members share certain rights and freedoms to comment and/or express their views about TCHD or other ~~W~~workforce ~~M~~members; however, the comments and/or expressions may subject themselves to legal action if found defamatory. Caution should be used by ~~W~~workforce ~~M~~members when commenting on TCHD to ensure statements are accurate and opinions are clearly expressed as opinions and not as the view of TCHD, ~~W~~workforce ~~M~~members, patients or affiliates.
   e. The release of public information relating to the general operations of TCHD is the responsibility of the Chief Executive Officer (CEO) or designee of TCHD. As such, ~~W~~workforce ~~M~~members are not permitted to post content or speak on behalf of TCHD unless authorized to do so. Workforce ~~M~~members may not say or suggest their views and/or opinions expressed relating to TCHD, health care, the medical field, the medical profession, or any other matter as representing the official views of TCHD.
   f. When using ~~S~~social ~~M~~media on behalf of TCHD, always be polite and courteous. Think before responding to criticisms and do not let haste cause problems.
   g. Be respectful of copyright and fair use laws, attributing quotes, only quote short excerpts of other people's material, and link others' work.

D. PROCEDURE:
1. Promptly report every breach of confidentiality or privacy to Risk Management, Regulatory, Human Resources, and/or the direct manager.
2. Forward all media and other public requests for information regarding operations of the TCHD to the CEO or to the Chief of Government and External Affairs.
3. Report workplace concerns to the Human Resources ~~d~~Department or the management team and do not post on ~~S~~social ~~M~~media.
4. Social Media Best Practices ~~f~~Form will be completed by each ~~W~~workforce ~~M~~member.
5. Failure to adhere to this policy, whether or not the policy has been acknowledged by the ~~W~~workforce ~~M~~member, may subject ~~W~~workforce ~~M~~members to disciplinary action up to and including termination of employment.

E. FORM(S):
1. Social Media Best Practices

F. ~~REFERENCES~~RELATED DOCUMENT(S):
1. Administrative District Operations Policy: ~~212~~ Use of Personal Electronic Appliances 8610-212
2. Administrative District Operations Policy: ~~257~~ Cellular Phones and Other Wireless Electronic Digital Devices Use Of 8610-257

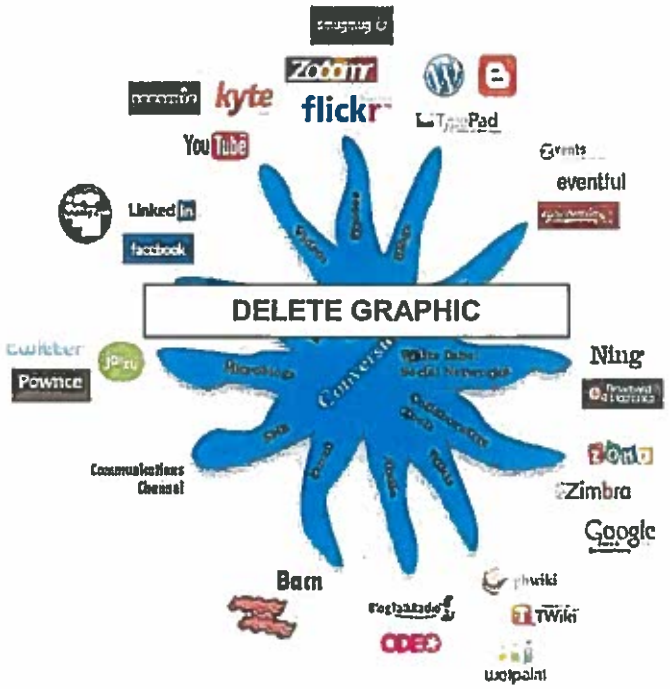
3. **Administrative Patient Care Policy: ~~372~~ Consent to Photograph/Videotape 8610-372**
4. **Administrative Human Resources Policy: ~~403~~ Discrimination, Harassment, and Retaliation Prevention 8610-463**
5. **Administrative Human Resources Policy: ~~455~~ Confidentiality 8610-455**
6. **Administrative Information Technology Policy: ~~609~~ Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information 8610-609**

G. **REFERENCE(S):**

1. CHA Consent Manual ~~2010~~2017
2. HITECH Act 2009
3. State and Federal Privacy of Health Information Laws (SB 541, SB 337)
4. ~~**Tri-City Healthcare District Social Media Best Practices**FORM REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~

~~Tri-City Medical Center~~
~~Oceanside, California~~

~~Administrative Policy Manual~~
~~Human Resources~~
TRI-CITY HEALTHCARE DISTRICT
Social Media Best Practices



There's no such thing as "private" social media sites. Search engines can ~~turn up~~**show** internet postings years after the original publication date, even when it'~~-~~is believed that such content has been deleted or changed. Comments and postings can be forwarded or copied to hundreds of people.

Tri-City ~~Medical Center~~**Healthcare District** ~~employees~~**Workforce Members** may not use or disclose any patient information of any kind on any social media without the express written permission granted by the patient.

Remember even if you do not believe that you have identified a particular patient, even if that patient's name is not used or his or her medical record number has not been identified, you may still be disclosing information that allows others to identify the patient. If another individual can identify or presume to believe that the information ~~that~~ you provide has identified a patient at Tri-City ~~Medical Center~~**Healthcare District**, then the use or disclosure of this information may constitute a violation of the Health Insurance Portability and Accountability Act (HIPAA). Such violations may be reported to the County Public Health Department, any applicable professional Board, and could be referred to the Office of the Inspector General (OIG). Such disclosures would also be reported to the patient.

Caution is recommended in using social networking and media sites such as Facebook, Twitter, MySpace~~.~~, Yahoo!-Groups, **Instagram, Snapchat,** Wikis, LinkedIn, blogs, ~~when~~ texting, or when using or accessing any other social media **website and/or application**. When using social media on behalf of Tri-City ~~Medical Center~~**Healthcare District**, ~~if you post~~**posting** unprofessional or inappropriate comments or material~~, then such posts~~ reflects poorly on you and on Tri-City ~~Medical Center~~**Healthcare District**. Such postings may become public and could subject Tri-City ~~Medical Center~~**Healthcare District** and you to unintended exposure to legal proceedings.

When using social media and networking sites, even for purely personal reasons, remember:

- Be respectful and professional to **patients and** fellow ~~employees and business partners~~**Workforce Members**;
- Never post information about a patient, **Workforce Member, or Tri-City Healthcare District's Proprietary and Confidential Information,** whether or not ~~the patient is identified~~**identifiable** by name, in any format, at any time, for any reason; and
- When identifying yourself as a Tri-City ~~Medical Center~~**Healthcare District** ~~employee~~**Workforce Member** ~~or when communicating about or to other employees~~, avoid ethnic slurs, personal insults, obscenity, or any communications that would not be acceptable at Tri-City ~~Medical Center's~~**Healthcare District's** workplace.

Employees who have concerns regarding workplace conduct or inappropriate use of ~~"~~Social Media~~"~~ are encouraged to contact their immediate supervisor or Human Resources for clarification regarding the terms of ~~this~~ **Administrative ~~p~~Policy: 479 Social Media**.

I understand that by signing this agreement I am stating that I will abide by and uphold these communication standards, and ~~that~~ I will be evaluated on these standards on an annual basis.

_____

Print ~~Employee~~ Name

_____ _____

~~Employee~~ Signature Date

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION ~~SERVICES~~

ISSUE DATE: **NEW** **SUBJECT: Fall Risk Assessment ~~Procedure~~**

REVISION DATE(S):

Cardiac Rehabilitation Department Approval:	**11/18**
Division of Cardiology Approval:	**12/18**
Medical Executive Committee Approval:	**02/19**
Administration Approval:	**~~03/19~~04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **DEFINITION(S):**

1. To provide a fall risk assessment on all patients prior to their first exercise session, and to implement appropriate fall risk interventions based upon patients' identified risk factors.

B. **PROCEDURE:**

1. A Fall Risk Assessment (form) is given to any patient who answers yes to any of the 4 questions asked on the Cardiac Rehabilitation Admission Information form filled out at patient's initial intake appointment.
2. On the Fall Risk Assessment form (7593-1037), if patient scores a 2 or higher, he/she is considered a fall risk. The supervising **physician**~~MD~~ will finish completing the form with the patient, giving education/intervention strategies and instruction as necessary. The **physician**MD alerts the staff of the fall risk prior to starting the exercise session.
3. The staff will highlight patient's name on chart and on his/her daily exercise prescription sheet with a yellow sharpie highlighter.~~.~~ Patient will also wear ECG monitor in a ~~yellow pouch (hospital site) or wear a bead necklace (Carlsbad site)~~**blue pouch with a red dot** during the exercise session.
4. Fall risk patients will not be able to use the treadmill or any other upright equipment unless accompanied/directly/closely supervised by a staff member. Patients may be re-evaluated as his/her strength, balance, and fitness level improves.

C. **FORM(S):**

1. Cardiac **Rehabilitation Physician Referral Orders - Sample**~~rehabilitation admission information~~
2. Fall Risk Assessment **- Sample**

SAMPLE

☐ **Tri-City Medical Center**
4002 Vista Way, Oceanside CA 92056
Phone: 760-940-3098, Fax 760-940-4056

☐ **Carlsbad Wellness Center**
6250 El Camino Real, Carlsbad CA 92008
Phone: 760-476-2905, Fax 760-931-3163

Patient Name: _____ DOB: _____

Home Phone: _____ Cell: _____

DIAGNOSIS: **Date of Onset or Intervention:**

- ☐ Acute Myocardial Infarction STEMI (within 1 year of infarction) _____
- ☐ Non-STEMI (within 1 year of infarction) _____
- ☐ Coronary Artery Bypass Graft surgery _____
- ☐ Stable Angina Pectoris _____
- ☐ Heart Valve Repair or Replacement _____
- ☐ CHF (EF documented < 35%) _____
- ☐ Percutaneous Transluminal Coronary Angioplasty _____
- ☐ PTCA with Coronary Artery Stenting _____
- ☐ Heart Transplant _____
- ☐ Phase IV Supervised Maintenance Program (Oceanside site only) _____

PROGRAM OPTIONS / TREATMENT PLAN:

☐ Phase II Continuous Telemetry Monitored Cardiac Rehab, duration based on patient progress to a maximum of 36 sessions in 12-18 weeks
- Initial Evaluation Nursing Assessment
- Progressive exercise training 3 times per week, 30-60 minutes per session, utilizing treadmill, stationary bike, hand weights, steps/recumbent stepper, elliptical, and other conditioning activities
- Education to promote an active healthy lifestyle and reduction of personal health risk factors

INTENSITY:

☐ Patient will be exercised to tolerance with the following restrictions:
- ☐ None
- ☐ Based on Stress Test, completed on _____
- ☐ Heart Rate Range: _____ - _____
- ☐ Maximum Heart Rate: _____

Restrictions: _____

☐ My patient does not require a graded exercise test prior to starting the cardiac rehab program.
☐ My patient has had a graded exercise test and we will fax it to the Cardiac Wellness Program.
☐ My patient is able to participate in the cardiac rehabilitation MAINTENANCE program, where he/she will only be ECG monitored for 3 visits. This option is self-pay, and no insurance authorization is necessary. All fees will be the responsibility of the patient (Oceanside site only).

☐ Phase IV Cardiac Rehab Maintenance Program (Oceanside site only)

- ☐ Supervised exercise without Telemetry monitoring

☐ Read Back all T.O./V.O.orders	
Nurse's – Signature Date Time	Physician's – Signature Date Time

Affix Patient Label

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CARDIAC REHABILITATION PHYSICIAN REFERRAL ORDERS
Page 1 of 1
PHYSICIAN'S ORDERS

SAMPLE

FALL RISK ASSESSMENT, INTERVENTION, AND EDUCATION

Initial ☐ Reassessment ☐

Reason for reassessment: Recent Fall ☐ Medication Change ☐

Other ☐ _____

_____

Check all measures that apply

☐ Dizziness / disorientation
☐ Medical problems affecting ambulation
☐ History of falls within the last six months
☐ Receiving medications affecting balance or mobility
☐ Use of assistive devices / ambulatory aids

_____ *Total number of measures checked*

No Fall Risk = Score of 0 or 1 ☐

Fall Risk = Score of 2 or higher ☐

**** If a score of 2 or higher, need Fall Risk Interventions and Education**

☐ Initiate individualized treatment recommendations and interventions / note on initial treatment plan
☐ Educated patient regarding medication side effects
☐ Educated patient prone to dizziness to move slowly
☐ Instructed patient to rise out of chair slowly
☐ Educated patient regarding use of assistive devices to prevent falls
☐ Educated patient regarding wearing proper shoes and walking near walls or with assistance
☐ Educated regarding calling out loud for help as needed for assistance
☐ Alerted staff regarding the patient being at risk for falls

I understand the information I have been given to help me prevent falls.

_____

Patient Signature Date / Time

_____

Physician Signature Date / Time

Affix Patient Label

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7593-1037
(Rev 11/12)

FALL RISK ASSESSMENT

Tri-City Medical Center
Oceanside, California

DELETE: Policy incorporated into Bed Utilization Policy.

INTENSIVE CARE UNIT

ISSUE DATE:

SUBJECT: CLOSURE OF BEDS

REVISION DATE: 3/00, 5/01, 10/02, 04/11

POLICY NUMBER: ICU 1

Intensive Care Unit Department Approval	**03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	05/03, 5/2011

~~A. Closure of beds in the ICU is up to the discretion of the Clinical Manager/Charge Nurse.~~

~~B. The ICU may close either 1 West/1 East when the combined unit census is 10 patients or less.~~

~~C. Prior to closure of a unit, the charge nurse is responsible for communication with the Administrative Supervisor to evaluate the potential need for critical care beds by other departments.~~

~~D. Patient acuity and patient safety will be taken into consideration when deciding which unit to close.~~

~~E. Unit Secretary will follow the direction of the charge nurse as to room assignments and change patient location in the computer.~~

~~F. Phones will be forwarded to designated unit.~~

~~G. Patient medications must be removed from the refrigerator and locked area above the medication pyxis and moved to the designed unit.~~

~~H. Notify Pharmacy to lock Pyxis medication stations on closed side.~~

~~I. 2 code blue nurses are assigned from the unit that remains open. The crash cart and defibrillator on the closed unit must still be checked every shift.~~

~~J. The code blue response defibrillator will remain on 1 East and code blue drugs will remain in the refrigerator on 1 West. It is the responsibility of the code blue RN to check the crash cart and defibrillator on the closed unit.~~

~~K. The charge nurse or designee must check the emergency procedure trays on 1 East and 1 West.~~

~~L.~~A. ~~Maintain communication with Staffing Office for evaluation if reopening is necessary.~~

Tri-City Medical Center
Oceanside, California

INTENSIVE CARE UNIT ~~Policy Manual~~

ISSUE DATE: 01/08	**SUBJECT: ICU Post-Op Heart Cart**
REVISION DATE(S): ~~04/11~~05/11	~~**POLICY NUMBER: ICU 5**~~
Intensive Care Unit Approval:	03/17
Critical Care Committee Approval:	n/a
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	04/19
Professional Affairs Committee:	n/a
Board of Directors Approval:	~~1/08,~~ 5/11

A. **POLICY**

1. The Intensive Care Unit (ICU) Post-Operative Heart cart shall be checked at least daily for integrity and outdates by the ICU Assistant Nurse Manager~~/Heart Nurse~~ **or designee.**
   a. This is ~~a~~ documented by date, shift, and signature in the Assistant Nurse Manager Logbook maintained in the procedure cabinet located behind the ~~1 East (1E)~~ **1 West (1W)** nurse's station.
2. Sterile Processing Department (SPD) and Pharmacy shall be notified by the ICU Assistant Nurse Manager **or designee** to immediately replace any supplies and/or medications used during an emergency heart procedure.
   a. After the supplies and/or medications are replaced, the cart shall be locked. ~~with a purple lock.~~ These locks are kept in the top drawer of the cart.
3. Pharmacy is responsible for checking the outdate sticker for medications due to expire on a monthly basis. This is documented by date and signature on the Nursing Unit Inspection from located in the main Pharmacy.
4. The ICU Post-Operative Heart Cart List shall be kept on the cart.
   a. The list shall be maintained and updated by SPD and Pharmacy.
5. The Critical Care Committee is responsible for maintaining and updating the ICU Post-Operative Heart Cart contents based on recommendations from the Cardiovascular Surgery Team.
   a. The Committee will review this policy at least annually.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**02/90**	**SUBJECT:**	**Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds**
REVISION DATE(S):	**01/03, 03/09, 11/10, 01/11**	**POLICY NUMBER:**	**8710 – 522**

Medical Staff Department Approval:	~~03/17~~02/19
Department of Emergency Medicine Approval:	~~03/17~~02/19
Credentials Committee Approval:	~~04/17~~02/19
Pharmacy ~~and~~ & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**
1. The purpose of this credentialing process is:
   a. To define the core privileges for ultrasound in Emergency Medicine.
   b. To outline the two pathways by which Emergency Physicians and Physician Assistants may demonstrate competency in basic emergency ultrasonography.

B. **CORE PRIVILEGES:**
1. Limited obstetrical ultrasonography, both transabdominal and endovaginal, to verify intra-uterine pregnancy.
2. Limited abdominal ultrasonography including limited renal, evaluation for abdominal aortic aneurysms, and Focused Abdominal Sonography for Trauma (eFAST) to evaluate for evidence of free intraperitoneal fluid, pericardial fluid, and pneumothorax.
3. Procedural guidance for procedures Emergency Physicians and Physician Assistants are credentialed to perform in a blinded manner, including but not limited to central line placement, paracentesis, thoracentesis, pericardiocentesis, and drainage of soft tissue fluid collections.

C. **CREDENTIALING PATHWAYS:**
1. In accordance with the 2007 Model of Clinical Practice of Emergency Medicine as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American College of Emergency Physicians (ACEP) policy statement for emergency ultrasound guidelines, two pathways are recognized to demonstrate proficiency in emergency ultrasound.
   a. Residency-based Pathway which requires demonstration of completion of an ACGME-approved Emergency Medicine residency program that includes training in emergency ultrasonography.
   b. Practice-based Pathway which requires both of the following:
      i. Completion of a formal course in basic emergency medicine ultrasound covering the core applications with both didactics and practical hands-on sessions.
      ii. Experiential training period during which the practitioner must perform a minimum of ~~25~~ cases in each of core privileges #1 and #2 above.
         1) During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.
         2) The proctoring shall be conducted by emergency physicians already credentialed in basic emergency medicine ultrasonography.

iii. Core privilege number 3, procedural guidance privileges, has no proctoring requirement if the practitioner is already credentialed to do the procedure in a blinded fashion.

D. **REFERENCE(S):**

1. American College of Emergency Physicians 2008 Ultrasound Credentialing Guidelines
2. Core Privileges for Physicians, Fourth Edition, 188-195.
3. ACGME 2007 Model of Clinical Practice of Emergency Medicine
4. American Medical Association House of Delegates Resolution 802 and policy 230.989.

~~Tri-City Health Care District~~
~~Oceanside, California~~

~~Medical Staff Policy Manual~~

DELETE: This policy has been incorporated into Patient Care Services Policy: Fire Prevention and Management in Invasive Procedure Areas

ISSUE DATE: 01/10

SUBJECT: Prevention of Fire in Head & Neck Surgery

REVISION DATE(S): 01/10

POLICY NUMBER: 8710-560

Medical Staff Department Approval:	03/17
Department of Medicine Approval:	~~12/09~~06/17
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/10~~07/17~~03~~/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/10

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

~~1. To heighten awareness of increased fire risk during head and neck surgery.~~

~~2. Communication between the healthcare team is essential in order to provide a safe environment. For Head and Neck surgical procedures, the following protocol will be activated by the Anesthesia Team.~~

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

~~1. Head and neck surgery: Head and neck surgery is any procedure performed on the body above the level of the xiphoid process.~~

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

~~1. All staff involved with head and neck surgery shall collaborate before and during the surgical procedure to prevent or manage a fire.~~

~~2. At all times, the minimum concentration of oxygen shall be used to provide for adequate oxygenation of the patient.~~

~~3. Oxygen will be administered at FiO2 of 0.30. Total Fresh Gas flow of 12L/min or greater shall be utilized for this to prevent rebreathing of expired gases and dilution by room air.~~

~~4. The anesthesia provider will alert the surgical team of the need to increase the inspired oxygen concentration if acceptable oxygen saturation is not obtained using this concentration.~~

~~a. Oxygen shall be titrated up incrementally to achieve adequate oxygen saturation.~~

~~i. FiO2 of 0.35 or greater, the surgical team will re-assess the fire safety precautions planned for the procedure, and make any adjustment necessary to ensure ignition potential and fuel sources have been minimized.~~

~~5. Consider delivery of 5-10L/min of air under the drapes to wash out excess oxygen.~~

~~D. **PRIOR TO START OF THE PROCEDURE:**~~

~~1. Document Fire Risk Safety Assessment as a part of the preoperative Time Out; including:~~

~~a. The use of the appropriate anesthesia machine if BiPAP modality is needed.~~

~~b. The need for 100% oxygen for open delivery during head and neck surgery.~~

~~i. Consider the use of medical air rather than oxygen if patient condition permits.~~

~~ii. Consider the use of suction to scavenge the area under the drapes when open delivery oxygen is used.~~

~~iii. Consider the use of laryngeal mask airway (LMA) for monitored anesthesia care with moderate to deep sedation.~~

~~c. Allowance of alcohol based preparatory agents to dry thoroughly and fumes to dissipate.~~

~~d. Arrangement of the drapes to minimize oxygen buildup.~~

i. If possible, use incise drapes to isolate the head and neck area from oxygen and flammable vapors.

e. Water or saline is available and labeled on the sterile field, both in a basin/pitcher and in an irrigation syringe. In addition, a 30-60mL labeled syringe of saline shall be available within reach of the anesthesia cart.

f. The use of the appropriate laser resistant endotracheal tube when the laser is in use.

i. A cuffed rather than uncuffed tube is preferred.

1) The cuff shall be inflated with saline and the use of methylene blue to tint the saline is advised to act as a marker for cuff puncture.

ii. Consider packing wet sponges around the back of the throat to retard oxygen leaks.

g. Using water-soluble lubricating jelly to coat facial hair (i.e., eyebrows, beard, and mustache) to ensure the hair is non-flammable.

h. A tracheotomy tray or cricthyroidectomy kit immediately available.

i. Verbally confirming heat source settings with the surgeon and using the lowest settings possible.

E. DURING THE PROCEDURE:

1. The surgical team shall manage ignition sources, fuel, and oxidizers.
2. The use of bipolar electrocautery during tracheal or oral surgery is preferred.
3. The anesthesiologist shall be provided adequate warning when:
   a. The trachea will be opened
   b. The ignition source is activated in the presence of open gas delivery
      i. If possible, stop supplemental oxygen at least one minute before and during ESU/Laser use, or decrease the oxygen concentration to the minimum required to avoid hypoxia.
      ii. If possible, stop the use of nitrous oxide one to three minutes before and during use of ESU/Laser.
4. During oropharynx surgery, consider the use of suction to scavenge the field prior to use of the ignition source.
   a. Metal suction tips are preferred over plastic suction tips.

F. REFERENCE(S):

1. Lippincott Williams & Wilkins, Inc. Practice advisory for the prevention and management of operating room fires. Anesthesiology 2008; 108:786-801.

Approvals:

Medical Department Approval: 12/09
Medical Executive Committee Approval: 01/10
Board of Directors Approval: 01/10

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 01/17 **SUBJECT: Consultation To Perinatal Unit**

REVISION DATE(S):

Women and Newborn Services Department NICU Approval:	**~~11/16~~01/19**
Perinatal Collaborative Practice Approval:	**~~11/16~~01/19**
~~Division of Neonatology Approval Date:~~	**~~11/16~~**
Pharmacy ~~and~~ & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/16~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~01/17~~ n/a**
Board of Directors Approval:	**01/17**

A. **DEFINITION(S):**

1. Perinatal Unit: A perinatal unit means a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space, equipment and supplies.

B. **POLICY:**

1. A neonatologist or Allied Health Professional (AHP) shall be available for perinatal unit consults as requested by an OBGYN or Certified Nurse Midwife.

Tri-City Medical Center	Women's & and Children's Newborn Services Manual — Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**EYE EXAMINATIONS FOR RETINOPATHY OF PREMATURITY AND/OR OTHER HIGH RISK EYE DISORDERS**
Purpose:	Retinopathy of Prematurity (ROP) is a disorder in the development of the vessels of the retina. The clinical result is visual impairment, including at its worst, blindness. Timely treatment may save an infant's sight. Therefore, it is essential that premature infants be examined by an ophthalmologist prior to discharge and/or according to the timetable spelled out in the criteria below to determine if this disorder is present.
Equipment:	NICU Eye Exam Instrument Kit Sucrose and pacifier Eyedrop (mydriatic/cycloglegic) medication

A. **CRITERIA FOR EXAMINATION**

1. All infants less than ≤1500 grams birth weight or ≤30 weeks gestation. ~~will have an ophthalmology examination between 4-6 weeks chronologic l age or by 31 weeks postmenstrual age, whichever comes first~~.
2. ~~2.~~ Select infants with a birth weight between 1500 and 2000 grams or gestational age of greater than 30 weeks who have had an unstable clinical course placing them at high risk for **ROP**~~eye problems~~ (as determined by the attending neonatologist). ~~will have an eye examination at 4 weeks chronologic age.~~
3. **The following is the recommended timing of the first eye examination:**

Gestational age at birth	Age at Initial Examination (~~,~~ weeks)	
	Postmenstrual	Chronologic
23	31	8
24	31	7
25	31	6
26	31	5
27	31	4
28	32	4
29	33	4
30	34	4
Older with risk factors		4

B. **POLICY**

1. The RN shall:
   a. Confirm that an order has been placed by the physician for an eye exam **and provide the unit secretary with the patient's name and date of ordered eye exam.**
   ~~b. Note the exam on the Neonatal Discharge Sheet~~
   ~~c.~~**b.** Educate parents on the reason for Retinopathy of prematurity (ROP) examinations and provide educational handouts. Instruct **the parent/caregiver**~~them~~ at discharge **regarding** the importance of timely follow-up if outpatient examinations are indicated.
2. The unit secretary shall:
   a. Contact the ophthalmologist office to schedule examination when the order is entered.

Women and Newborn Services NICU Department Review	Department of OB/GYN	~~Division of Neonatology~~Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy &and Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 01/19	n/a	12/14, 01/19	n/a	n/a	02/15, 03/19	0419	~~03/15~~n/a	03/15

b. **On the day of exam, c**~~C~~omplete the following on the ROP Ophthalmic Examination Record including: **(to be completed by the charge nurse or bedside RN if unit secretary is not available)**
   i. Date of examination
   ii. Birth Weight
   iii. Gestational age at birth

~~c. Copy the patient face sheet~~

~~d.~~**c.** Note the exam in the unit logbook following the exam.

3. The ophthalmologist shall:
   a. Call the ~~day assistant nurse manager/relief~~ charge nurse with a time for examinations for the following day or the day of the examination.
   ~~a.~~**b. Confirm type, dosage and timing of eye drops to be instilled.**
   ~~b.~~**c.** Use **NICU eye exam instrument kit** ~~equipment~~ provided by TCMC. ~~The assistant nurse manager/relief~~ charge **nurse or bedside nurse** shall ensure that the equipment is **at the bedside** ~~in the NICU~~ prior to the examination.

~~4. The physician performing the exam shall:~~
   ~~a. On the night before eye exams or the morning of the eye examination, shall order the eye drops to be instilled.~~

C. **PROCEDURE:**

1. **Perform hand hygiene and don gloves.**~~Wash hands, put on gloves.~~
2. Confirm patient identity **per hospital policy**~~using two identifier system~~.
3. **Gently** ~~P~~**p**ull the lower lid downward, using 2x2s if necessary, and instill **ordered dose of eye drops** ~~two drops of Cyclomydril~~ into the lower conjunctival sack, then release lid. Wipe away any excess with a sterile 2x2. Repeat for other eye. Repeat eye drop instillation process per physician ordered interval.
   a. Be aware that infants can experience apnea, bradycardia, and feeding intolerance as a result of the eye drops.
   b. If the examination shall occur near the time of an infant's feed, it is prudent to delay the feed until the procedure has been completed. If the infant is receiving feeds by the continuous method, turn off the pump 15 minutes prior to the examination. Resume all feeds when procedure has been completed. If the infant is experiencing any **side** ~~untoward~~ effects, **notify** ~~consult with~~ the physician.
4. Remove gloves and wash hands.
5. Discard the individual bottle of eye drops.
6. **Confirm patient identity with Ophthalmologist, prior to exam.** Assist ophthalmologist with the examination and ensure that gowning and hand washing policies are observed.
   a. The eye examination is painful and stressful for the neonate therefore non-pharmacological comfort measures should be taken such as sucrose pacifier and swaddling.
7. Observe patient for bradycardia, usually caused by pressure on the baby's eyes **and document any episodes in the EMR.** ~~Document in detail any episode.~~
8. Care should be taken to protect the eyes from bright light for 4-6 hours after mydriasis.
9. The examining ophthalmologist~~, based on retinal findings,~~ shall recommend follow up examinations **based on retinal findings.**

D. **REFERENCE(S)**

1. AAO/AAP (201~~83~~). Screening Examination of Premature Infants for Retinopathy of Prematurity.*Pediatrics*, **142:~~6131:1, 189-195~~**.
2. Ikuta, L.M. & Beauman, S.S. (Eds.). (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. National Association of Neonatal Nurses.
3. Verklan, M. T. & Walden, M. (2016~~0~~). Core Curriculum for Neonatal Intensive Care Nursing, 4th ed. St. Louis: Elsevier Saunders.

Tri-City Medical Center	Women's and Newborn~~Children's~~ Services– Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PRE/POST WEIGHTS FOR BREASTFED INFANTS IN THE NICU**
Purpose:	To use the weight scale as a means of quantifying intake at the breast in order to ensure optimal nutrition and support the mother/infant breastfeeding dyad.
Equipment:	Breastfeeding scale

A. POLICY:

1. The use of a breastfeeding scale to approximate an infant's intake at breast can be a valuable tool in assessing an infant's progress towards discharge. Its use, however, should be limited to those infants whose intake may be less than optimal due to their disease process, such as prematurity or infant of a diabetic mother. The primary goal is to encourage the breastfeeding mother and establish a long-term breastfeeding dyad. Regardless of the intake amount, the mother will be encouraged with the message that every time her baby is at the breast is a "successful" feeding.

B. PROCEDURE:

1. Pre/Post weights are **not** necessary for the following infants:
   a. Infants less than 3 days of life unless **Mother of Baby**~~OB~~ is consistently pumping volumes of at least 10ml, when lacotogensis II has occurred.
   b. Infants greater than 36 weeks gestation without feeding problem (ie not on **Occupational Therapy**~~T~~ service)
2. Indications for obtaining pre and post breastfeeding weights once milk supply has been established:
   a. Infants less than 36 weeks gestation
   b. Term infants with identified feeding problems
   c. As ordered by the neonatologist
3. Pre/Post weights shall continue until the baby is no longer requiring gavage feeds **AND** demonstrates the ability to take full feedings ~~at the breast~~.
4. Before feed weight (pre-weight)
   a. Weights are to be measured in grams only
   b. Turn scale on and verify it is "zeroed"
   c. Swaddle infant and disconnect leads from monitor. Place monitor on "Standby"
   d. Place swaddled baby on scale. All leads and feeding tubes should be placed on top of bundled baby. Any leads or tubing unable to be disconnect (ie, running IV) should be held up and off scale by RN.
   e. RN to keep one hand just above baby for safety.
   f. Wait until scale determines weight. "Set" weight in scale per manufacturer's instructions. Remove baby from scale, hand to mother, reconnect leads and resume monitoring.
   g. Record set pre-weight.
   h. Diaper, clothing and blanket should not be changed between the "before" and "after" weights.
5. After-feed Weight (post-weight)
   a. Ensure scale is on and either has retained previous weight or is "zeroed"
   b. Weigh baby again using exact same technique as previous weight. Ensure no changes have been made in diaper, clothing, etc. and infant is swaddled in same blanket.
   c. RN to keep one hand hovering above infant at all times.
   d. Wait until scale determines weight and value locks into scale. Remove infant and place in a safe location. Reattach leads and resume monitoring.
   e. Record the post weight and calculate amount fed.

Women and Newborn Services NICU Department Review	~~Department of OB/GYN~~	Perinatal Collaborative Practice	~~Department of Pediatrics~~	Pharmacy ~~and~~ & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/18~~2/14~~01/19	~~3/14~~	01/19	~~3/14~~	n/a	5/14, 03/19	04/19	~~10/14~~n/a	11/14

f. Chart the amount fed in the infant's ~~EMR~~ **Electronic Medical Record** as mls of 20 cal ~~BM~~ **Breast milk** intake.

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

1. Meir PP, Engstrom JL, Test weighing for term and preterm infants is an accurate procedure, Arch Dis Child Fetal Neonatal Ed. 2007 March; 92(2): F155-F156
2. Spatz, DL. Innovations in the Provision of Human Milk and Breastfeeding for Infants Requiring Intensive Care.JOGNN. 2011; 41, 138-143
3. Spatz, DL. Ten Steps for Promoting and Protecting Breastfeeding for Vulnerable Infants. Journal of Perinatal and Neonatal Nursing. 2004; 18(4) 385-396.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

~~TRI-CITY MEDICAL CENTER~~

~~4002 Vista Way, Oceanside, California~~

ISSUE DATE: 09/91 **SUBJECT:** Home Evaluation

REVISION DATE(S): 01/94, 12/96, 03/00, 01/06, 03/12, 06/13 **POLICY NUMBER:** 504

Rehabilitation Department Approval:	~~1/03, 1/09, 3/13~~10/17
Department of Medicine Approval:	01/19
Pharmacy & Therapeutics Committees Approval:	n/a
Medical Executive Committee Approval:	~~N/A~~03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~ISSUE DATE: 9/91~~
~~REVISION DATE: 1/94, 12/96, 3/00, 1/06, 3/12~~
~~REVIEW DATE: 1/03, 1/09~~
~~SUBJECT: HOME EVALUATION~~
~~STANDARD NUMBER: 504~~
~~CROSS REFERENCE:~~
~~APPROVAL:~~

~~This Policy / Procedure applies to the following Rehabilitation Services' locations:~~

- ~~4002 Vista Way, Oceanside, CA~~
- ~~161 Thunder Drive, Suite 112, Vista, CA~~
- ~~6250 El Camino Real, Carlsbad CA~~

~~A. PURPOSE~~

~~B. To assess patient mobility in home to include accessibility, identification of safety hazards, and to assess the need for specialized equipment.~~

A. POLICY:

1. The primary OT, PT and/or SLP **(if appropriate)** will assess if patient requires a home evaluation. The home evaluation will be conducted while the patient is receiving inpatient acute rehabilitation.~~.~~

~~C.~~B. PROCEDURE:

1. At least one staff OT or PT will conduct the home evaluation. Other participants may include OTA, PTA, SLP, Rehab Aide or interns~~.~~
2. Therapist(s) will coordinate **the** home evaluation time **and discuss transportation arrangements for patient** with ~~patient's~~**their** family ~~members~~**member/caregiver prior to the evaluation**.
3. Transportation for patient will ~~either~~ be provided by ~~Tri-City Medical Center van services or by~~ **the** patient's family.
4. ~~A~~**A temporary absence** release form must be filled out by the patient or ~~significant other~~**representative** before **the** home evaluation. A ~~copy~~**form** is placed in the chart, and a copy is given to the patient.

~~5. Therapist(s) should sign out patients on board at the Rehabilitation Station.~~

5. ~~Therapist~~**The therapist will leave documentation of their scheduled trip at Rehab Services with address of the Home Evaluation location and an emergency number which includes a**

work and one personal contact phone number. The therapist will carry a copy of this with them in the car.

6. **The therapist(s) will notify the patient's nurse about the patient's absence from the unit due to the Home Evaluation.**
~~6.~~**7.** **The therapist**(s) are responsible for taking ~~needed~~**necessary** equipment, ~~i.~~**e.g.:** tape measure, bath bench, transfer boards, and appropriate forms, on **the** home ~~education~~**evaluation**.
8. ~~Therapist~~**The therapist**(s) will document results of ~~home evaluation in~~**Home Evaluation in the medical** chart and order any specialized equipment.
9. **Home Evaluation with concurrent patient discharge from TCMC to their home may occur at times. A discharge home is determined by the patient's physician at TCMC and is based on the patient meeting pre-established functional and medical safety criteria. The physician may reconsider patient discharge home following specific findings of the Home Evaluation.**

C. **FORM(S):**
~~7.~~**1. Temporary Absence Release Form -- Sample**

Temporary Absence Release Form – Sample

A patient outing (explain activities to occur during patient outing) _____

_____

_____ will occur away from the hospital at

(location) _____

on (date) ___/___/___ and will last approximately (time) _____(AM/PM) to_____(AM/PM).

Patients who participate in the outing are accompanied by hospital employees or agents who are responsible for the supervision of the patients and for providing or arranging, when appropriate, transportation by hospital vehicles or commercial carriers to and from the activity. A patient may participate in the outing if his/her physician deems such participation therapeutically appropriate and beneficial. However a patient may continue to receive other services from the hospital even if permission is not given for participation in the outing, which is a special treatment modality.

Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of the time during and subsequent to the time a patient is away from the hospital. If private or public insurance does not provide such hospitalization benefits, the patient or the person responsible for the patient's hospitalization expenses will remain, to the extent permitted by law obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners. Your signature below constitutes your acknowledgement: (1) that you have read and agree to the forgoing; (2) that the patient outing noted above has been adequately explained to you by your/ the patient's physician and that you have received all the information you desire concerning the outing; and (3) that you authorize and consent to the participation of (patient name) _____in such outing.

_____

Patient/Conservator/Guardian/Other Signature Date / Time

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/Conservator/Guardian/Other)

Affix Patient Label

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

CONSENT FOR PARTICIPATION IN TRI-CITY HOSPITAL PATIENT OUTING

7790-1014
(Rev 2/13)

White - Hospital Yellow - Patient

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

DELETE: Information included in Rehabilitation Services: Therapy Daily Note Procedure.

SUBJECT: OCCUPATIONAL THERAPY: DAILY NOTE, INPATIENT
POLICY NUMBER: 1202

ISSUE DATE: 09/91
REVISION DATE(S): 09/96, 10/99, 09/02, 01/03, 01/06

Rehabilitation Department Approval:	08/15
Department of Medicine Approval:	01/19
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**ISSUE DATE:** 9/91~~
~~**REVISION DATE:** 9/96, 10/99, 9/02, 1/03, 1/06~~
~~**REVIEW DATE:** 2/94, 10/97, 1/09, 4/12~~

~~**SUBJECT: OCCUPATIONAL THERAPY: DAILY NOTE, INPATIENT**~~
~~**STANDARD NUMBER: 1202**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

~~**A. PURPOSE**~~

~~1. A daily note will be entered into the Medical Record when Occupational Therapy Services have been rendered.~~

~~**B. POLICY**~~

~~1. Daily notes will include the following:~~
~~a. Date, time of day, treatment rendered in military time, length of treatment, time note was entered, and signature of therapist rendering service.~~
~~b. Treatment procedures, how patient responded, family education, and treatment plan.~~
~~b. Any significant information or change in patient's status.~~
~~2. Treatment time included in note will coincide with treatment units billed.~~
~~3. Recommendation for subsequent treatment/equipment needs will be documented as applicable.~~

Tri-City Medical Cer
Oceanside, California

REHABILITATION SERVIC

DELETE: Information included in Rehabilitation Services: Therapy Daily Note Procedure.

SUBJECT: Occupational Therapy Outpatient Daily Note

ISSUE DATE: 09/91
REVISION DATE(S): 09/96, 10/9, 09/02, 01/03, 01/06

Rehabilitation Department Approval:	08/15
Department of Medicine Approval:	01/19
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**ISSUE DATE:** 9/91~~
~~**REVISION DATE:** 9/96, 10/99, 9/02, 1/03, 1/06~~
~~**REVIEW DATE:** 2/94, 10/97, 1/09, 4/12~~

~~**SUBJECT: OCCUPATIONAL THERAPY: OUTPATIENT DAILY NOTE**~~
~~**STANDARD NUMBER: 1203**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

~~A. **PURPOSE**~~

~~1. A daily note will be entered into the Medical Record when Occupational Therapy Services have been rendered.~~

~~B. **POLICY**~~

~~1. Daily notes will include the following:~~
~~a. Date, time of day, treatment rendered in military time, length of treatment, time note was entered, and signature of therapist rendering service.~~
~~b. Treatment procedures, how patient responded, and treatment plan.~~
~~c. Any significant information or change in patient's status.~~
~~2. Treatment time included in note will coincide with treatment units billed. CPT codes billed will be recorded, with treatment minutes documented.~~
~~3. Recommendation for subsequent treatment/equipment needs will be documented as applicable.~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 09/91	**SUBJECT: Occupational Therapy ~~Policy~~**
REVISION DATE(S): 01/94, 09/97, 03/00, 01/03, 01/06, 01/09, 03/10, 04/12	**POLICY NUMBER: 702**

Rehabilitation Department Approval:	**~~07/15~~03/18**
Department of Medicine Chiefs Approval:	**~~02/16~~01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~03/16~~ n/a**
Board of Directors Approval:	**03/16**

A. **POLICY:**

1. Occupational Therapy is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
2. Occupational Therapy Staff reports to the Leadership Structure in fulfilling duties and responsibilities.

B. **PROCEDURE:**

1. Requests For Service
   a. All requests for occupational therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP).
   b. Verbal requests for occupational therapy services will be accepted, but must be followed by a written order.
   c. A new order is required for any change in medical status or treatment ordered.
2. Hours Of Service
   a. Inpatient care: Monday through Sunday, 0800 to 1630 for inpatient care.
   b. Outpatient: Monday through Friday, 0700 to 1630.
   c. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities
   a. Provides occupational therapy evaluations and treatment as prescribed by a licensed physician or AHP.
   b. Administers an assessment of Occupational Performance.
   c. Develops an Intervention Plan for each individual with designated goals based upon the individual's medical condition, assessment and personal goals.
   d. Develops Outcomes and Measures to assess the individual's progress or regression.
   e. Implements the Intervention Plan, utilizing specific activities or methods to develop or restore function, compensate for dysfunction or minimize debilitation.
   f. Engages in Intervention Plan Review, modifying treatment based on established Outcomes and Measures, as clinically indicated and medically necessary.
   g. Treatment may include but is not limited to:
      i. Use of therapeutic tasks and purposeful activities to promote psychological, cognitive, physical, sensory integrative and developmental functioning.

ii. Facilitate and educate in graded self-care and daily-living tasks, socialization skills, pre-vocation skills, vocational roles, and community reintegration with regard to patients' privacy and dignity. This may involve instructing in the use of compensatory techniques; selecting, constructing and instructing in the use of adaptive devices, orthoses, and prostheses; ordering appropriate equipment and recommending adaptation of the individual's physical environment to enable optimal function.

iii. Use of exercises and other specific techniques such as those to promote relaxation, restore movement, strength and posture in preparation for functional training.

h. Documents patient treatment and treatment outcomes in patient's legal record per American Occupational Therapy Association/Centers for Medicare and Medicaid Services Guidelines for Documentation of Occupational Therapy.

i. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.

j. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.

k. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.

l. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

C. **REFERENCE(S):**

1. American Occupational Therapy Association.(2014).Occupational therapy practice framework: Domain and process (3rd ed.).*American Journal of Occupational Therapy, 68*(Suppl.1), S1–S48.http://dx.doi.org/10.5014/ajot.2014.682006
2. Gloria Frolek Clark, M. J. (2013). Guidelines for Documentation of Occupational Therapy. (T. C. 2012, Ed.) *American Journal of Occupational Therapy, 67*(November/December), 32-38.
3. Centers for Medicare & Medicaid Services. (2015, May). *Therapy Services.* Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
4. Centers for Medicare & Medicaid Services. (2015, May). *Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.* Retrieved from www.cms.gov:

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

DELETE: policy been merged with Rehabilitation Staff Meetings Policy

SUBJECT: Outpatient Team Conferences
POLICY NUMBER: 511

ISSUE DATE: 8/88
REVISION DATE(S): 1/91, 2/94, 9/97, 10/99, 1/06, 1/09

Rehabilitation Department Approval:	**08/15**
Department of Medicine Approval:	**01/19**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~ISSUE DATE: 8/88~~
~~REVISION DATE: 1/91, 2/94, 9/97, 10/99, 1/06, 1/09~~
~~REVIEW DATE: 1/03, 5/12~~

~~SUBJECT: OUTPATIENT TEAM CONFERENCE & MEETING~~
~~STANDARD NUMBER: 511~~
~~CROSS REFERENCE:~~
~~APPROVAL:~~

~~POLICY MANUAL:~~

~~A. PURPOSE~~

~~1. To promote communication between therapeutic disciplines and develop an integrated team approach to outpatient therapy~~

~~B. ORGANIZATION~~

~~1. The physical or occupational therapy supervisor will assume responsibility for coordinating and facilitating the outpatient team~~**~~Interdisciplinary~~** ~~conferences and meetings. All appropriate outpatient members will attend conferences and meetings. Non-patient care issues that need addressing will be developed on an agenda.~~

~~C. MEETINGS~~

~~1. Conferences will typically will meet on a~~**~~no less than~~** ~~once a month basis and will be scheduled on a routine basis. A separate outpatient team meeting will also meet once every other month to address non-patient issues.~~**~~, subject to change per departmental and patient care needs.~~**

~~D. CRITERIA FOR OUTPATIENT TEAM CONFERENCE/MEETING~~

~~1. Any patient receiving services may be discussed at team conference. Other patients' cases will be presented at the discretion of the therapists.~~

~~E. DESCRIPTION OF TEAM CONFERENCE~~

~~PROCEDURE:~~

~~1. Staff members discuss the patient's history, problems, progress and any other pertinent information. Therapeutic goals are discussed, and methods to best integrate all therapeutic disciplines are~~

identified. Discussion, although structured and informal, is designed to encourage creativity in treatment planning. Discharge planning will also be discussed, as well as appropriateness for referral to other community resources as needed.

2. An outpatient team meeting is held on an every other month basis. Its purpose is to provide an open forum for outpatient Rehabilitation staff members to present opportunities for improvement that have been identified. The meeting also promotes communication among staff members and disciplines. If issues cannot be readily resolved, an interim team may be formed to specifically address significant items if necessary (Focus PDCA). Participants include the area discipline manager/supervisor, outpatient physical therapists, occupational therapists, assistants and aides, and outpatient office staff members as appropriate.

F. RECORDS

1. A copy of the team conference notes will be kept in the Outpatient Team Conference notebook. A notation that the patient's case was discussed will be entered in the patient's medical record by the participating therapists.
2. A copy of the Team Meeting notes/minutes will be kept in Outpatient Meetings binder.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 01/91 **SUBJECT: Physical Therapy**

REVISION DATE(S): 01/94, 09/97, 03/00, 01/03, 01/06, 01/09, 03/10, 04/12, 03/16 **POLICY NUMBER: 603**

Rehabilitation Department Approval:	**~~07/15~~03/18**
Department of Medicine Chiefs Approval:	**~~02/16~~01/19**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~03/16~~ n/a**
Board of Directors Approval:	**03/16**

A. **POLICY:**

1. Physical Therapy is accountable through the Rehabilitation Services Leadership Team and/or Medical Director of the rehabilitation program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate Administrative Executive to the Administrator for carrying out the policies and procedures as approved by the Governing Board.
2. Physical Therapy staff report directly to the Rehabilitation Services Leadership Team in fulfilling duties and/or responsibilities.

B. **PROCEDURE:**

1. All requests for Physical Therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP). AHP must be working in collaboration with a physician.
2. Verbal requests for Physical Therapy services will be accepted, but must be followed by a written prescription.
3. A new signed prescription is required for any change in medical status or treatment ordered.
4. Outpatient appointments are scheduled between 0700 and 1800 Monday through Friday.
5. Inpatients are seen between 0800 and 1630 Monday through Sunday according to prioritization policy.
   a. Therapy provision may occur outside of these time frames on an as needed basis.
6. Physical Therapy evaluations and treatment will be provided as prescribed by a licensed physician or an AHP.
7. Appropriate assessments/tests will be administered to develop a treatment plan.
8. A written treatment plan will be provided with time frames for each individual with designated functional goals, based upon the individual's medical condition, evaluation and test results, and personal goals.
9. Initial and ongoing treatment will be implemented utilizing specific activities or methods to develop or restore function, relieve pain, compensate for dysfunction or minimize debilitation. Treatment may include but is not limited to:
   a. The use of physical agents such as thermotherapy, cryotherapy, hydrotherapy, electrical stimulation, ultrasound, and mechanical traction.
   b. Therapeutic exercise and activities, manual therapy and joint mobilizations.
   c. Neuromuscular re-education, gait training, vestibular integration.
   d. Manual lymphatic drainage and bandaging.

10. Treatment will be modified based upon progression towards therapeutic goals as clinically indicated and medically necessary.
11. Patient treatment and treatment outcomes will be documented in the patient's legal record according to appropriate documentation policies.
12. Patient's physician will be provided with a written summary of the patient's evaluation, progress and designated discharge plan for treatments.
13. All therapy equipment will be maintained in quality condition.
    a. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.
14. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.
15. Appropriate operational and administrative records will be maintained, may include but not limited to licensure, certifications, timecards, training records, and billing sheets.
16. Reporting and consulting with appropriate healthcare professionals regarding patient's current status will be maintained and documented.

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

1. Documentation of Evaluations
2. Documentation of Daily Notes
3. Documentation of Progress Notes
4. Documentation of Discharge Summaries

D. **REFERENCE(S):**

1. California Physical Therapy State Practice Act. (n.d.). Physical Therapy Board of California. Retrieved July 7, 2015, from Physical Therapy Board of California Website: http://leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2620-2634

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

DELETE: Policy not needed.

SUBJECT: PROVISION OF REHAB SERVICES NOT PROVIDED BY TRI-CITY MEDICAL CENTER
POLICY NUMBER: 106

ISSUE DATE:
REVISION DATE(S): 1/91, 1/94, 4/97, 10/99, 12/02, 2/03, 1/06, 1/09, 3/12

Rehabilitation Department Approval:	~~09/15~~10/15
Department of Medicine Approval:	01/19
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~ISSUE DATE:~~

~~REVISION DATE: 1/91, 1/94, 4/97, 10/99, 12/02, 2/03, 1/06, 1/09, 3/12~~
~~REVIEW DATE:~~

~~SUBJECT: PROVISION OF REHAB SERVICES NOT PROVIDED BY TRI-CITY MEDICAL CENTER~~
~~STANDARD NUMBER: 106~~

~~CROSS REFERENCE:~~
~~APPROVAL:~~

~~A. PURPOSE~~

~~1. To establish a protocol for the provision of rehabilitation services not provided by Tri-City Medical Center.~~

~~B. POLICY~~

~~1. Rehabilitation Services not provided by Tri-City Medical Center will be provided through either contracted services or referral to an outside service. Contract services may be provided for Physical, Occupational, and Speech Therapy through registry services. Referrals to outside services will be made by a physician and coordinated through ancillary services for the following: Orthotics and Prosthetics, Vocational Rehabilitation, Psychology/ Neuropsychology, Podiatry.~~

~~C. CONTRACT SERVICES~~

~~1. **Therapy Registry Service:** To appropriately provide adequate staffing levels, the use of Therapy Registries may be required. Current contracts are maintained and the Registries may be used in the event outside staffing is required to adequately provide quality patient care. As with all contract services, quality of patient care is subject to review through the Rehabilitation Services Quality Assessment/ Improvement Plan. A copy of the Registry Therapist's license and orientation is kept on file when the services are rendered.~~

~~D. REFERRAL SERVICES~~

~~1. **Orthotics and Prosthetics Services:** Primary services are provided by SCOPe (Southern California Orthotics & Prosthetics). Orthotic and prosthetic representatives consult with Tri-City Medical Center's Rehabilitation Services Department frequently and actively participate in the department's gait evaluations when needed. Current patients may be fitted prior to their~~

~~discharge from therapy to monitor fit, proper function and adequate education of orthosis and prostheses throughout their therapy. The Orthotist/Prosthetist is responsible for documenting any patient interactions and issuing equipment. Referrals to this service may be initiated by Physical Therapy or Occupational Therapy; however, a physician's referral is mandatory.~~

2. ~~**Psychological, Neuropsychological Services, & Podiatry:** Referrals for Psychological/Neuropsychological, and Podiatric services are made by a physician~~

3. ~~**Vocational Rehabilitation Services:** Referrals for Vocational Rehabilitation services are made by a physician. These services are available to our patients through the Department of Rehabilitation in San Diego. (See attached letter from the State of California Health & Welfare Agency and the Vocational Rehabilitation Department Policy.)~~

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**08/90**	**SUBJECT:**	**Referrals for Rehabilitation Services**
REVISION DATE(S):	**01/91, 01/94, 09/97, 10/00, 01/03, 01/06, 01/09, 03/10, 04/12, 06/13**	**POLICY NUMBER:**	**509**

Rehabilitation Department Approval:	**09/15**
Department of Medicine Approval:	**01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**ISSUE DATE:** 8/90~~	~~**SUBJECT: REFERRALS FOR REHABILITATION SERVICES**~~
~~**REVISION DATE:** 1/91, 1/94, 9/97, 10/00, 1/03, 1/06, 1/09, 3/10, 4/12, 6/13~~	~~**STANDARD NUMBER: 509**~~
~~**REVIEW DATE:** 3/13~~	~~**CROSS REFERENCE:**~~ ~~**APPROVAL:**~~

A. **PURPOSE:**

1. Rehabilitation services are rendered according to the written orders of a Physician **or an Allied Health Professional (AHP),** ~~**or a NPP(Non-Physician Provider**~~ **such as a Physician Assistant, Clinical Nurse Specialist** ~~and/~~or Nurse Practitioner~~)~~. The Physician/**AHP** ~~and/or Nurse PractitionerA NPP (Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ is to determine the need for therapy, the tolerance and capabilities of the patient and the treatment objectives.
   a. The Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~, in consultation with the therapist, must prescribe the specific procedures/modalities to be used and the frequency and duration of treatment.
   b. The referring Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ should then notate ~~his~~ **the** order on the Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ order sheet in the patient's chart, for inpatients; or complete an appropriate referral form, or his own personal prescription form, with the required information for outpatients.
   c. The dated prescription must include a specified diagnosis or description of the problem, therapy orders, frequency and duration, and a signature.
   d. These forms will then be forwarded to the Rehabilitation Services Department.

B. **REQUESTS FOR SERVICE:**

1. Verbal orders may be taken by a physical therapist, occupational therapist, or speech and language pathologist from a Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician~~

~~Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~.

2. These must be charted and signed by the physical therapist, occupational therapist or speech and language pathologist read back and verified with the ordering Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ verbatim.
3. A written order shall be obtained from the referring Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ within a reasonable time frame.

C. **HOURS OF SERVICE:**

1. Inpatients are seen for an evaluation within 24 hours for PT, OT and high-priority Speech patients 7 days a week.
2. Referrals received after 4 PM on Friday for Speech are evaluated within 72 hours.
3. Outpatients are scheduled as quickly as possible, not to exceed 7 business days.

D. **RESPONSIBILITIES:**

1. Rehabilitation services must be provided by, or under, the supervision of a Rehabilitation Services staff member who meets the qualifications established by applicable federal, state and local laws and regulations.
2. Whenever a rehabilitation service is given by a person who does not meet these regulations, the qualified therapist shall be immediately available to supervise and/or handle any emergency that may arise during treatment.
3. After the initial assessment is completed, the Physician/**AHP** ~~and/or Nurse PractitionerA NPP(Non Physician Provider such as a Physician Assistant, Clinical Nurse Specialist and/or Nurse Practitioner).~~ will sign off on the therapist's proposed plan of care. The sign-off will be in the form of a clarification order (inpatient)~~,~~ or an updated therapy prescription form (outpatient) or by signing the therapist's evaluation/report and plan of care (outpatient).

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 7/91

SUBJECT: Scope of Services

REVISION DATE(S): 01/94, 05/95, 04/97, 10/00, 05/01, 02/03, 01/06, 01/09, 03/12, 03/16

POLICY NUMBER: 104

Rehabilitation Department Approval:	**~~07/15~~03/18**
Department of Medicine Approval:	**~~02/16~~01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/16~~03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~03/16~~ n/a**
Board of Directors Approval:	**03/16**

A. **POLICY:**

1. The Department of Rehabilitation Services includes Physical, Occupational, and Speech Therapies, Audiology, and Therapeutic Recreation. Using a multidisciplinary collaborative team approach, services and programs are available to meet the needs of all patients with a wide variety of diagnoses, including physical and psychosocial disabilities. The overall objective of the Department is to foster a healing environment for patients to regain their functional independence in all areas of daily life as rapidly as possible. Assessment identifies the patient's physical, cognitive, behavioral, communicative, emotional and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include:
   a. Emotional, behavioral or mental disorders
   b. Cognitive disorders
   c. Communicative disorders
   d. Developmental disabilities
   e. Vision or hearing impairments or disabilities
   f. Physical impairments or disabilities
   g. Pain interfering with optimal level of function or participation in rehabilitation
2. Each patient, inclusive of neonatal through geriatric ages, will be treated with dignity and respect. Optimal health care services will be delivered to each patient regardless of gender, size, disability, race, creed, or ethnic origin.
3. Physical Therapy - The goals of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning. Physical Therapy Services shall include, but are not limited to, evaluation/assessment, development of treatment plans and goals, instruction, education and consultation services.
4. Occupational Therapy - The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skills required for daily living activities. Services include evaluation and treatment for impairments of physical, psychosocial, cognitive, developmental and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and compensate for or cope with disabling conditions.
5. Speech Pathology - Speech-Language Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders. These include, but are not limited to, impairments of articulation, language comprehension and

expression, cognition, fluency, voice, reading, writing and swallowing. Education and counseling for families of patients exhibiting the aforementioned disorders are also provided.

6. Audiology Services – Audiology Services include assessment of hearing acuity and status in patients who may be at risk for changes in hearing due to medical or treatment issues, including medication, age or diagnosis. Instruction and education of patients and family members is provided to increase the involved person's understanding of their deficits.
7. Therapeutic Recreation - Therapeutic Recreation Services provide goal-oriented programs that promote wellness and improve the patient's quality of life through leisure. Therapeutic Recreation treatment may be individual or done in groups. Services include, but are not limited to, leisure assessment and evaluation, skill development, social programs, special events, leisure education, leisure counseling and resource development. Family education and counseling are included to improve patient's attitude, skill level and socialization.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**09/91**	**SUBJECT:**	**Therapeutic Recreation Department Policy**
REVISION DATE(S):	**01/94, 09/97, 01/06, 01/09, 04/12, 05/12**	**POLICY NUMBER:**	**901**

Rehabilitation Department Approval:	**09/15**
Department of Medicine Approval:	**01/19**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**03/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~ISSUE DATE: 9/91~~ ~~SUBJECT: THERAPEUTIC RECREATION DEPARTMENT POLICY~~
~~REVISION DATE: 1/94, 9/97, 1/06, 1/09, 4/12, 5/12~~ ~~STANDARD NUMBER: 901~~
~~REVIEW DATE: 2/03~~ ~~CROSS REFERENCE:~~
~~APPROVAL:~~

~~A. PURPOSE~~

~~1. The Therapeutic Recreation Department is responsible for providing evaluation and therapeutic recreation treatment for patients referred to the department.~~

A. **POLICY:**

1. Patients referred for therapeutic recreation will be evaluated, and recommendations will be established~~, unless otherwise~~ **as clinically** indicated.

~~1.~~2. ~~The~~ Therapeutic recreation ~~Department~~ is accountable through the **leadership structure of** rehabilitation services ~~Committee~~ and~~/or Medical Director of each rehabilitation program and/or~~ the referring physician**/Allied Health Professional (AHP)** for maintaining a competent level of practice. The department is also accountable through the appropriate administrative executive ~~to the Administrator~~ for carrying out the policies and procedures as approved by the Governing Board.

~~2. REPORTING~~

~~1.~~3. Therapeutic recreation **staff** reports ~~directly~~ to the ~~Supervisor of OT/TR and to the Orthopedic Service Line Administrator~~**leadership structure** in fulfilling ~~duties~~**duties or** /responsibilities.

B. **PROCEDURE:**

~~E.~~1. Requests for Service:

~~1.~~a. All requests for therapeutic recreation services must be in the form of a written prescription from a licensed physician**/AHP**.

~~2.~~b. Verbal requests for therapeutic recreation services will be accepted, but must be followed by a written prescription.

~~3.~~c. A new requisition is required for any change in treatment ordered.

~~F.~~2. Hours of Service:

a. ~~Variable~~**Inpatient care: Monday through Sunday, 0800** to ~~meet the needs~~**1630.**

~~1.~~i. **Therapy provision may occur outside** of ~~patients and program 7 days a week~~**these time frames on an as needed basis**.

~~6.~~3. Responsibilities:

~~1.~~a. Provides therapeutic recreation evaluations and treatment to rehabilitation unit, behavioral health inpatient unit, and acute care, as prescribed by a licensed physician/**AHP**.

~~2.~~b. Administers appropriate assessments and tests prior to the initiation of treatment.

~~3.~~c. Provides a written plan for each individual with designated goals based upon the individual's medical condition, age-appropriate considerations, evaluation and test results, and personal goals.

~~4.~~d. Implements initial and ongoing treatment programs while maintaining patient privacy, utilizing leisure education that focuses on assisting the patient in learning new leisure skills, redeveloping past leisure skills, and establishing an awareness of self and leisure opportunities. Assists the patient and family in adjustment to disability and a change in lifestyle patterns through the use of recreational activities.

~~5.~~e. Modifies treatment program based upon medical status, progress/lack of progress, or as requested by the patient's physician/**AHP**.

~~5.~~f. **In the acute care setting patients will be seen at bedside unless otherwise indicated. Leisure materials may be left for unsupervised individual to use at bedside~~,~~ with nursing informed ~~as to~~of any safety concerns and program continuity.**

~~6.~~g. Documents patient treatment and treatment outcomes in patient's record.

~~7.~~h. ~~Maintains therapy~~ **Identifies safety hazards and** equipment in ~~good working~~**disrepair, removes hazard or equipment and inputs work** order~~ and stores in an organized manner.~~.

~~8.~~i. Demonstrates ~~fiscal responsibility in utilization~~**fiscally responsible decision making including the prudent use** of **therapy equipment and supplies~~,~~ and conservation of time and** resources ~~and notifies supervisor of supply shortages~~ in a ~~timely manner~~**manner that maintains desired income and expense ratios.**

~~9.~~j. Maintains appropriate operational and administrative records;~~,~~ **may include but not limited to licensure, certifications, timecards, training records, and billing sheets; as per department guidelines.**

~~11. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.~~

~~Provides educational inservices regarding Therapeutic Recreation evaluation and treatment.~~

Tri-City Medical Center
Oceanside, California

DELETE POLICY PER DEB FELLER, no longer have SPRA

PERI-ANESTHESIA NURSING SERVICES POLICY MANUAL

ISSUE DATE: 10/11 SUBJECT: SCOPE OF SERVICE FOR SPRA

REVISION DATE(S):

Department Approval:	05/18
Department of Anesthesiology Approval:	01/19
Operating Room Committee Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	04/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. ~~PURPOSE: To describe the Scope of Service for the Special Procedures Recovery Area (SPRA) department at Tri-City Medical Center.~~

~~B. POLICY:~~

~~1. GOALS~~

~~a. To improve the general health and well-being of inpatients and outpatients requiring recovery from procedures in Cath Lab, Interventional Radiology (IR) and special procedural areas, and outpatient infusions and blood transfusions.~~

~~b. To reduce and manage complications and unexpected outcomes.~~

~~c. To continuously evaluate and improve the services provided.~~

~~2. DESCRIPTION OF SERVICE & ASSESSING DEPARTMENT SERVICES~~

~~a. The SPRA department provides nursing care to patients requiring recovery from procedural sedation in Cath Lab and IR, and receiving outpatient infusions and blood transfusions, Monday-Friday 8:00am-4:30pm.~~

~~3. METHODS USED TO ASSESS PATIENTS' NEEDS~~

~~a. Patient assessment and care is performed by a SPRA Registered Nurse (RN).~~

~~b. For patients recovering from Cath Lab or IR procedures, the SPRA RN receives hand-off report from the procedural RN.~~

~~4. SCOPE OF SERVICES~~

~~a. SPRA is a 15 bay unit, including accommodations for 9 beds and 6 chairs.~~

~~b. Patients are discharged from the SPRA when written discharge criteria are met. Patients may be discharged home or to the next appropriate level of care, per physician order. For complete details about patient discharge criteria, see PANS Policy: Post-Anesthesia Patient Discharge-Transportation Guidelines.~~

~~5. STAFFING AND AVAILABILITY OF STAFF~~

~~a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the SPRA.~~

~~b. Staffing is maintained in a nurse-to-patient ratio of 1:4 to 1:2, depending on patient acuity. A unit secretary is staffed Monday-Friday 7:30am-5pm.~~

~~6. PATIENT POPULATION & INTERNAL & EXTERNAL CUSTOMER DESCRIPTION~~

~~a. Adult and geriatric patients requiring recovery from Cath Lab, IR and special procedures, and infusion and blood transfusions.~~

~~b. Internal customers served include other nursing units, physicians, patients, families, and all ancillary departments in the hospital.~~

c. External customers served include, but are not limited to: home health care services, area nursing homes, area rehabilitation facilities, medical supply companies, other contracted medical service companies and the local community.

7. EXTENT TO WHICH THE DEPARTMENT'S LEVEL OF CARE/SERVICE MEET PATIENT NEEDS

a. The nursing services provided by SPRA meet the needs of both patients through availability of staff who are competent to provide services for the current patient population.

8. PERFORMANCE IMPROVEMENT (PI)

a. In order to improve patient care, several indicators for patient care are monitored and reported quarterly to Quality Control Council.

b. SPRA PI projects are incorporated with the PACU PI Committee meet every other month, with minutes maintained in the binder in the PACU clean utility room.

9. STANDARDS OF PRACTICE

a. SPRA follows practice recommendations as outlined in the American Society of PeriAnesthesia Nurses (ASPAN).

b. The nursing service abides by regulations of California Title XXII, Joint Commission guidelines, CMS and the Board of Registered Nursing.

10. MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT

a. Medications, general and narcotics, are dispensed via the Pyxis system. Medications requiring refrigeration are obtained from PACU Pyxis.

b. Medications not available in the Pyxis are obtained from Pharmacy.

c. Blood products are obtained from the Transfusion Services, located in the general laboratory.

d. All medications administered are documented on the paper record.

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
PERI-ANESTHESIA NURSING SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/11 **SUBJECT:** Visitors in the Post Anesthesia Care Unit (PACU)

REVISION DATE(S):

~~Department~~ Surgical Services Department Approval:	**06/18**
Department of Anesthesiology Approval:	**n/a**
Operating Room Committee Approval:	**01/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**02/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide guidelines for limited admission of family members/significant others into the Post Anesthesia Care Unit. Recovery from anesthesia is a time of transition for patients during which their vulnerability necessitates specialized nursing care and attention. Due to the nature of the unit, visitors are admitted under special circumstances only as described in this policy. The safety and privacy of all patients in the PACU will take priority at all times.

B. **PROCEDURE:**

1. During normal hours & circumstances, patients recovering from anesthesia may require a family member/significant other at the bedside for a period of time. Those circumstances are limited to:
   ~~a. Pediatric patients <14 years of age will have both parents permitted in PACU~~
   ~~b.~~**a.** Patients with special needs, such as developmental delay, may have one family member/caregiver in the PACU **as requested by the RN.** ~~in some circumstances~~
   ~~c.~~**b.** At the time of discharge, same day surgery patients may have **a their designated responsible person** ~~designated competent adult~~ with them for ~~assistance with~~ **the** discharge **process.** ~~procedures or instructions~~
   ~~d.~~**c.** In the event of a prolonged **PACU** stay ~~if~~ **of** > 3 hours **or more,** ~~in the PACU,~~ a brief visit ~~not to exceed 5 minutes~~ may be possible depending on patient condition and activity in the unit at that time.
2. During early morning hours when the PACU space is utilized for the pre-operative preparation of patients, one **person** ~~family member (as determined by the patient)~~ may accompany the patient at the time the primary nurse designates ~~it~~ appropriate. This will depend on:
   a. Type and amount of preparation required for the procedure
      i. Additional preoperative testing required
   b. Regional blocks administered by anesthesiologist
   c. Activities in the unit **at that time**
3. **Visitors with signs of infection or illness, including but not limited to, fever, nausea, vomiting, coughing, sneezing, or sore throat will not be permitted.**
4. **Children under the age of 14 years old will not be permitted.**
5. **Exceptions will be made at the discretion of the manager/director or PACU charge RN.**
   ~~1. After 4 to 5pm when outpatient PACU (SPRA) & Pre-op hold are closed.~~
   ~~a. Generally visitors in PACU will not be possible during the busy afternoon & evening hours. Exceptions will apply as listed above, and at the discretion of the PACU Charge Nurse/Assistant Nurse Manager.~~

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN~~CHILDREN'S~~ SERVICES ~~POLICY MANUAL~~

ISSUE DATE: ~~**NEW**~~ **SUBJECT: Placenta Release to Patient/Family Except for Those Sent to Pathology**

REVISION DATE(S):

Women and Newborn Services Department Approval:	**~~06/2013~~10/18**
Department of OB/GYN Approval:	**~~06/2013~~10/18**
Department of Pediatrics Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/2014~~01/19**
Administration Approval:	**04/19**
Professional Affairs Committee Approval:	**~~11/2014~~ n/a**
Board of Directors Approval:	**11/2014**

A. **PURPOSE**:

1. In an effort to be culturally sensitive to our patient population's desires and requests, a placenta that **has not been sent to pathology for evaluation**, may be sent home with the patient if requested.
2. Maternal, fetal/neonatal, and placental indications for the placenta to be sent to pathology at the discretion of provider for examination can include, but are not limited to:
   a. Premature infant
   b. Prolonged rupture of membranes **greater than 18 hours**
   c. ~~Maternal~~ **Isolated maternal fever, Suspected Triple I or Confirmed Triple I**~~infection (suspect chorioamnionitis,~~ **(untreated** GBS~~+~~, etc.)
   ~~d. Intrapartum temperature > 100.4ºF (38ºC)~~
   ~~e.~~**d.** Low birth weight or IUGR
   ~~f.~~**e.** Congenital anomalies
   ~~g.~~**f.** Abruptio placenta
   ~~h.~~**g.** Post term infant
   ~~i.~~**h.** Fetal demise
   ~~j.~~**i.** Maternal medical problems
   ~~k.~~**j.** Maternal drug use
   ~~l.~~**k.** Multiple gestation
   ~~m.~~**l.** Placentas which appear abnormal (velamentous insertion of the cord, battledore, succenturiate, circumvallate, etc.)
   ~~n.~~**m.** 2 vessel umbilical cords
   ~~o.~~**n.** Abnormal blood gases
   ~~p.~~**o.** Meconium-stained placentas
3. The placenta will not be released to the patient if she has a known blood borne illness to include, but not limited to: HIV, Hepatitis, and Syphilis.
4. If the patient desires to take her placenta home after discussion with her provider and there is NOT an indication for examination, the patient will be given the "**Informed Consent for Authorization to Release Placenta from Hospital, Assumption of Risk and Waiver of Liability**~~Consent for Placenta Removal from the Hospital~~" to read and sign.
   a. The signed form will be scanned into the patient's electronic medical record
   b. A copy of the form will be given to the patient.

B. **PROCEDURE**:

1. Notify the provider if the patient requests to take her placenta home.

2. The provider will determine if there is an indication to send the placenta to pathology for examination and if not, write an order indicating the release of the placenta to the patient, as appropriate. If the placenta will be released to the patient, the patient will be given the "**Informed Consent for Authorization to Release Placenta from Hospital, Assumption of Risk and Waiver of Liability**~~Consent for Placenta Removal from the Hospital~~" form to read and sign.
   a. The form will be scanned into the patient's electronic medical record and a copy of the form will be given to the patient.
3. Immediately after delivery:
   a. Place the placenta in a clear plastic zip lock bag and then into another plastic zip lock bag (double bag). Put the double bagged placenta into a leak-proof, covered container and label it with the patient name and delivery time. Please also indicate on the container: "HOLD ON UNIT, FOR PATIENT RELEASE".
   b. Put the labeled container into the unit's lab specimen refrigerator in the Biohazard room to keep it refrigerated until the patient or designated transporter can take it home. (DO NOT SEND THE PLACENTA HOME WITH A BIOHAZARD LABEL OR IN A RED BIOHAZARD BAG)
   c. The patient/family must take possession of the placenta and remove it from the hospital premises within 6-12 hours after delivery.
4. A placenta that has been ~~removed from the delivery room or~~ sent to pathology will not be released to the patient.
5. The California Department of Public Health has reported that a placenta is not a bio hazardous waste as defined in Section 117635 of the California Health and Safety Code, if it has not been suspected of being contaminated with infectious agents.

C. **FORM(S):**

1. **Informed Consent for Authorization to Release Placenta from Hospital, Assumption of Risk and Waiver of Liability - Sample** ~~Consent for Placenta Removal from the Hospital~~

D. **REFERENCE(S):**

1. **The American College of Obstetricians and Gynecologists Committee Opinion. Intrapartum Management of Intraamniotic Infection. Number 712. August 2017.**
2. **Buser, G.L., Mato, S., Zhang, A.Y., Metcalf, B.J., Beall, BI, Thomas, A.R.** ***Notes from the Field:*** **Late-Onset Infant Group B Stregptococcus Infection Associated with Maternal Consumption of Capsules Containing Dehydrated Placenta-Oregon, 2016. MMWR Morb Mortal Wkly Rep 2017; 66:677-678.**
3. **Hester, D.M. (2008) Ethics by committee: consultations, organization and education for hospital ethics committees. New York. Rowmann & Littlefield**
4. **Obstet Gynecol. Evaluation and Management of Women and Newborns With a Maternal Diagnosis of Chorioamnionitis. 2016 March; 127(3): 426-436**

~~1.~~**5.** "Practice Guideline for Examination of the Placenta" developed by the Placental Pathology Practice Guideline Development Task Force of the College of American Pathologists; (Arch Pathol Lab Med, 1997; Vol 121, 449-476)

~~2.~~**6.** ~~Hester, D. M. (2008) Ethics by committee: consultations, organization and education for hospital ethics committees. New York, Rowmann & Littlefield.~~

SAMPLE

For personal, cultural, or religious reasons, I _____, have requested permission, and hereby authorize the release of my placenta from Tri-City Medical Center. In doing so, I understand and acknowledge that:

Tri-City Medical Center may deny the release of the placenta to me based upon clinical considerations.

I am fully informed and aware that examination of my placenta may provide important information about my recent pregnancy, any future pregnancies I may have, and information that is important to my health and my newborn child's health. I am fully aware of the risks of foregoing examination of my placenta and am aware that I acknowledge and aware that Tri-City Medical Center will be unable to perform further tests on this placenta.

Tri-City Medical Center has no responsibility for the safekeeping of the placenta once I have taken possession of it. I hereby accept full responsibility for undertaking precautions to prevent infection of myself and others. Infection may include, but is not limited to, HIV, Hepatitis, and Syphilis. I understand: **1. THE PLACENTA MUST BE KEPT IN A LEAKPROOF CONTAINER TO PREVENT CONTACT WITH PERSONS OR OBJECTS; 2. I WILL USE DISPOSABLE GLOVES WHEN HANDLING THE PLACENTA AND DISCARD THE GLOVES IN THE GARBAGE AFTER USE AND BEFORE TOUCHING ANYTHING ELSE; 3. I WILL WASH MY HANDS WITH SOAP AND WATER BEFORE AND AFTER CONTACT WITH THE PLACENTA; AND 4. I WILL DISINFECT ANY SURFACE THAT COMES INTO CONTACT WITH THE PLACENTA. I AGREE TO ACCEPT FULL RESPONSIBILITY FOR APPROPRIATE HANDLING, USE AND DISPOSAL OF THE PLACENTA.**

I ASSUME ANY AND ALL RISKS THAT MAY BE ASSOCIATED WITH MY REMOVING THE PLACENTA AND INGESTION OF SUCH PLACENTA, INCLUDING BUT NOT LIMITED TO, INFECTION TO ME OR OTHERS FROM BACTERIA, VIRUSES OR OTHER POTENTIALLY HARMFUL ORGANISMS THAT MAY BE PRESENT IN THE PLACENTA. I understand that Tri-City Medical Center is not advising, recommending or endorsing the ingestion of the placenta or any other use of the placenta by me, or any other person, for any purpose.

I, _____ on behalf of myself and my heirs, executors and assigns, release Tri-City Medical Center and its affiliates, including their employees, volunteers, representatives, officers, trustees, facility, and medical staff (collectively, Tri-City Medical Center), from any and all claims of liability for bodily injury, death, money damages or other loss arising out of or connected with Tri-City Medical Center's honoring my request for release of my placenta to me, or the eating or other use of my placenta by me or any other person.

Patient Name	Signature	Date / Time
Transporter Name	Signature	Date / Time
Provider Name	Signature	Date / Time
Witness Name	Signature	Date / Time

Affix Patient Label

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

7400-1067
(Rev 11/14)

INFORMED CONSENT FOR AUTHORIZATION TO RELEASE PLACENTA FROM HOSPITAL, ASSUMPTION OF RISK AND WAIVER OF LIABILITY

Community Healthcare & Alliance Committee (No meeting held in April, 2019)

Finance, Operations & Planning Committee (No meeting held in April, 2019)

Professional Affairs Committee
(No meeting held in
April, 2019)

Tri-City Medical Center
Audit, Compliance & Ethics Committee
April 16, 2019
Assembly Room 1
8:30 a.m. – 9:00 a.m.

Members Present:	Director Larry W. Schallock(Chair); Director George Coulter; Director Tracy Younger; Leslie Schwartz, Community Member Kathryn Fitzwilliam, Community Member (Subject Matter Expert)
Non-Voting Members:	Steve Dietlin (CEO); Ray Rivas, CFO; Scott Livingstone, COO; Carlos Cruz, CCO; Susan Bond, General Counsel
Others Present:,	Kristy Larkin, Director of Audit & Monitoring; Maria Carapia, Compliance Manager; Teri Donnellan, Executive Assistant
Absent:	Dr. Cary Mells, Physician Member

	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 Coulter and seconded by Mr. Leslie Schwartz 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 – February 19, 2019	**It was moved by Chairman Schallock and seconded by Director Coulter to approve the minutes of February 19, 2019 as presented. The motion passed with Mr. Leslie Schwartz abstaining from the vote.**	**Minutes ratified.**	
5. Old Business	None		
6. New Business a) Fiscal Year 2019 – Financial Statement Audit Proposal	Mr. Rivas reported at the Committee's direction he obtained a proposal from Moss Adams to conduct the FY2019 Financial Statement Audit. Mr. Rivas reviewed the terms of the proposal which included the regular Financial Statement		

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	Audit at a cost of $159,000, the issuance of the audit at a cost of $2,100 and the single audit which is a regulatory requirement due to our loan with HUD at a cost of $14,500. Mr. Rivas stated the fees represent an overall increase of 2.5% from 2018. Chairman Schallock commented that this is the third year of the single audit and the fees for that audit have been reduced to $14,500 from $20,000 in year one. Discussion was held regarding the audit selection process and the need to change auditors periodically which can be done in one of two ways: Engage a new outside firm or change audit partners. Ms. Fitzwilliam commented that it is not very cost effective to change firms due to the additional time involved for both the auditors and staff and it is common practice and best practice to rotate audit partners every five years. Mr. Rivas stated the current partner has been with us for two years. Mr. Rivas also reviewed the timing of the audit which will include a preliminary audit in May-June, the FY2019 Financial Statement Audit Entrance report to the committee in July, completion of fieldwork in August followed by discussion of the audit findings with the committee and recommendation to accept the audit by the Board in September. Mr. Rivas noted the committee will have the opportunity to ask questions of the auditors in the absence of staff. Ms. Fitzwilliam stated in her opinion it is in the best interest of the District to remain with Moss Adams as they are a medium sized firm with healthcare district experience and their fees are reasonable. Chairman Schallock noted should the committee be interested in changing firms in the future that selection process would need to be conducted in the fall due to the steep learning curve. **It was moved by Mr. Leslie Schwartz and seconded by Director Coulter to recommend approval of the FY2019 Financial Statement Audit Proposal as presented. The**	**Recommendation to be sent to the Board of Directors to approve the**	Ms. Donnellan

	Discussion	Action Recommendations/ Conclusions	rson(s) Responsible
	motion was approved unanimously.	**FY2019 Financial Statement Audit Proposal as presented; item to be included on Board agenda.**	
7. Comments from Committee Members	There were no comments from Committee Members.		
8. Committee Openings	Chairman Schallock reported there are two openings on the Committee due to the fact that Faith Devine has decided not to reapply due to relocation.	Information only	Ms. Donnellan
9. Date of Next Meeting	Chairman Schallock stated he anticipates the May 16, 2019 meeting may be cancelled and if so the committee will reconvene on July 16, 2019 at which time the Audit Entrance Report will be presented.	To be determined.	
11. Adjournment	Chairman Schallock adjourned the meeting at 8:45 a.m.		

MOSSADAMS

T (949) 221-4000
F (949) 221-4001

2040 Main Street
Suite 900
Irvine, CA 92614

February 27, 2019

Ray Rivas, Chief Financial Officer
Members of Audit Committee
Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Re: Audit and Nonattest Services

Dear Mr. Rivas:

Thank you for the opportunity to provide services to Tri-City Healthcare District. This engagement letter ("Engagement Letter") and the attached Professional Services Agreement, which is incorporated by this reference, confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Moss Adams LLP ("Moss Adams," "we," "us," and "our") will provide to Tri-City Healthcare District ("you," "your," and "Company").

Scope of Services – Audit

You have requested that we audit the Company's financial statements, which comprise the statement of net position as of June 30, 2019, and the related statements of revenues, expenses, changes in net position, and cash flows for the year then ended, and the related notes to the financial statements. We will also report on whether the schedule of expenditures of federal awards, schedule of mortgage reserve fund, and schedules of net position and revenues, expenses, and changes in net position, presented as supplementary information, are fairly stated, in all material respects, in relation to the financial statements as a whole.

In connection with our audit, we will include one or more paragraphs in our auditor's report accompanying the financial statements regarding whether matters came to our attention during our audit engagement related to your compliance with terms, covenants, provisions, or conditions of the Regulatory Agreement dated March 8, 2017, between the Company and the Department of Housing and Urban Development ("HUD") as required by Paragraphs 22(a) and 22(b) of the Regulatory Agreement.

Our report on the Company's compliance with aspects of the contractual agreement described above will state that our audit was not directed primarily toward obtaining knowledge regarding compliance with provisions of the contractual agreement described above. This report is intended solely for the information and use of the Company and HUD and is not intended to be and should not be used by anyone other than these specified parties. If, for any reason, we are unable to issue a report as a result of our procedures we will inform you of the termination of this engagement as soon as practical. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for all expenses. You acknowledge and agree that in the event we stop work or terminate the agreement for any reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

We understand that you will provide us with the basic information required for our procedures relating to compliance with aspects of the contractual agreement described above and that you are responsible for the accuracy and completeness of that information and ultimately for the Company's compliance with the contractual agreement.

Accounting standards generally accepted in the United States of America provide for certain required supplementary information ("RSI"), such as management's discussion and analysis, to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to the Company's RSI in accordance with auditing standards generally accepted in the United States of America. We will not express an opinion or provide assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide assurance. The following RSI will be subjected to certain limited procedures, but will not be audited:

- Management's discussion and analysis

Scope of Services and Limitations – Nonattest

We will provide the Company with the following nonattest services:

- Assist you in drafting the Data Collection Form as of and for the year ended June 30, 2019.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, Company management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.
- Oversee the service by designating an individual, preferably within senior management, who possesses skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.
- Accept responsibility for the results of the nonattest services performed.

It is our understanding that Ray Rivas, CFO has been designated by the Company to oversee the nonattest services and that in the opinion of the Company is qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

Timing

Stacy J. Stelzriede is responsible for supervising the engagement and authorizing the signing of the report. We expect to perform our interim work during the week of May 20, 2019, begin audit fieldwork on approximately August 5, 2019, complete final fieldwork on approximately August 30, 2019, and issue our report no later than September 27, 2019.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Fees

We estimate our fees as follows.

Deliverable	Amount
Financial Statement Audit as of and for the year ended June 30, 2019	$159,000
Issuance of separate audit report (excluding Single Audit) as of and for the year ended June 30, 2019	2,100
Requirements of HUD Loan • Single Audit Report • Procedures to provide negative assurance to HUD on the Company's compliance with debt covenants required under the Regulatory Agreement • Supplementary schedules of debt covenant ratios and other information as required under the Regulatory Agreement	14,500
Total	$175,600

In addition to the above fees, you will be billed for direct expenses at our cost as incurred for travel, meals, mileage, and other direct expenses. You will also be billed a flat fee of $1,000 for indirect expenses for processing and copying as well as estimated clerical and equipment costs.

The payment schedule for the services included on the previous page is as follows:

Month Due	Amount
March 2019	$ 5,000
May 2019	30,000
June 2019	30,000
July 2019	30,000
August 2019	30,000
September 2019	30,000
October 2019	20,600
Total	$175,600

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the Company's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments, and/or untimely assistance will result in an increase of our fees.

Reporting

We will issue a written report upon completion of our audit of the Company's financial statements. Our report will be addressed to the Board of Directors of the Company. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your financial statements for the year ended June 30, 2019.

At the conclusion of the engagement, we will complete the auditor section of the Data Collection Form and electronically sign the Data Collection Form that summarizes our findings. We will provide electronic copies of our reports to you; however, it is management's responsibility to electronically submit the reporting package (including financial statements, schedule of expenditures of federal awards, summary schedule of prior audit findings, auditors' reports, and corrective action plan, as applicable) along with the Data Collection Form to the Federal Audit Clearinghouse. The Data Collection Form and the reporting package must be submitted within the earlier of 30 days after receipt of the auditors' reports or nine months after the end of the audit period. At the conclusion of the engagement, we will make arrangements with management regarding Data Collection Form submission procedures.

Additional Services
You may request that we perform additional services not contemplated by this Engagement Letter. If this occurs, we will communicate with you regarding the scope of the additional services and the estimated fees. It is our practice to issue a separate agreement covering additional services. However, absent such a separate agreement, all services we provide you shall be subject to the terms and conditions in the Professional Services Agreement.

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in the Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

Stacy J. Stelzriede, Partner for
Moss Adams LLP

Enclosures

Accepted and Agreed:
This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Tri-City Healthcare District with respect to this engagement and the services to be provided by Moss Adams LLP:

Signature:_____

Print Name:_____

Title:_____

Date:_____

Client: #617641
v. 2/18/2019

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

March 28, 2019 – 2:00 o'clock p.m.
Classroom 7 – 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 2:00 p.m. on March 28, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Susan Bond, General Counsel
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Dr. Victor Souza, Chief of Staff
Noel Caughman, Board Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 2:00 p.m. in Classroom 7 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Schallock to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed unanimously (7-0).

3. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the March 28, 2019 Regular Board of Directors Meeting Agenda.

   There were no public comments.

4. Oral Announcement of Items to be discussed during Closed Session

Chairperson Grass made an oral announcement of the items listed on the March 28, 2019 Regular Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter of Potential Litigation, two matters of Existing Litigation, Hearings on Reports of the Hospital Medical Audit or Quality Assurance Committee, one Report Involving Trade Secret and approval of Closed Session Minutes.

5. Motion to go into Closed Session

It was moved by Director Chavez and seconded by Director Coulter to go into Closed Session. The motion passed unanimously (7-0).

6. The Board adjourned to Closed Session at 2:05 p.m.

8. At 3:30 p.m. in Assembly Rooms 1, 2 and 3, Chairperson Grass announced that the Board was back in Open Session.

The following Board members were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy M. Younger

Also present were:

Noel Caughman, Board Counsel (via teleconference)
Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Carlos Cruz, Chief Compliance Officer
Aaron Byzak, Chief External Affairs Officer
Susan Bond, General Counsel
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

9. Chairperson Grass reported the Board has expressed a desire to amend the agenda.

It was moved by Director Nygaard to add discussion and possible action of the SEIU-UHW contract to New Business item a) and renumber the existing items to b) and c) respectively. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. Director Coulter led the Pledge of Allegiance.

11. Chairperson Grass read the Public Comments section of the Agenda, noting members of the public may speak immediately following Agenda Item Number 24.

12. Report from TCHD Auxiliary – Mary Gleisberg, President

Ms. Mary Gleisberg, Auxiliary President gave a brief report of past and present activities, reviewing the following:

- There are presently 465 active volunteers; of those 177 are college "student volunteers";
- 15 volunteers have served more than 20 years or a minimum of 10,000 hours and one volunteer has served 34 years totaling 15,000 hours; and
- All volunteers attended a mandatory refresher update which is a yearly requirement

Upcoming Auxiliary events include the following:

- Scholarship Awards Night – Wednesday, April 24th
- Volunteer Appreciation Luncheon – Monday, April 28th
- Annual Installation Luncheon – Saturday, June 22nd

Ms. Gleisberg reported this month's Department Spotlight is Pet Therapy. Clinical Studies have shown Pet Therapy visits reduce stress and provides measurable health benefits to patients. Ms. Gleisberg explained how the Pet Therapy program works here at Tri-City where therapy dogs and their handler fulfill patient requests and visit the patient for 10-15 minutes. Pet therapy teams also visit the waiting rooms, interacting with visitors, children and most departments in the hospital. There are currently 12 active teams who visit throughout the week and participate in special events.

Ms. Gleisberg reported the pet therapy program began in 1989 and is under the Department of Rehabilitation. She noted all dogs are certified by a national pet therapy organization and undergo specific training and behavior evaluation.

Finally, Ms. Gleisberg introduced Shar Pauley and her therapy dog Calamity Jane who is approximately 13 years old and lost her front leg due to an accident. Ms. Pauley stated Calamity Jane loves spending time in the Rehab Department, comforting those who are sick and injured.

No action taken.

13. Report from Chief Financial Officer

Mr. Ray Rivas reported on the YTD Financials as follows (Dollars in Thousands):

- Net Operating Revenue – $235,439
- Operating Expense – $240,229
- EBITDA - $10,398
- EROE – ($76)

Other Key Indicators for the YTD driving those results included the following:

- Average Daily Census – 155
- Adjusted Patient Days – 66,961
- Surgery Cases – 4,280
- ED visits – 37,463

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Operating Revenue - $28,925
- Operating Expense - $29,362
- EBITDA - $1,468
- EROE – $99

Mr. Rivas commented on the fact that there were very high acuity patients this past month and our reimbursement is a fixed amount.

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 166
- Adjusted Patient Days – 8,037
- Surgery Cases – 474
- ED Visits – 4,472

Mr. Rivas reported on the following indicators for FY19 Average:

- Net Patient Accounts Receivable - $44.2
- Days in Net Accounts Receivable - 52.9

No action was taken.

14. New Business

a) Consideration of SEIU-UHW contract

Chairperson Grass recognized Miss Mali Woods-Drake, SEIU Representative who shared her gratitude for the collaboration and respect shown by both bargaining teams. Ms. Woods-Drake stated bargaining began on March 12, 2019 and tentative agreement was reached ten dates later. Ms. Woods-Drake introduced other members of the SEIU bargaining team who also expressed their gratitude for the manner in which negotiations were handled. Ms. Woods-Drake stated that union members felt confident that their three priorities (increased staffing, wages to market value and job security) were addressed. The SEIU Bargaining Team expressed their gratitude by presenting Mr. Dietlin with a thank you card.

It was moved by Director Nygaard that the Tri-City Healthcare Board of Directors approve the terms of the SEIU-UHW contract as tentatively agreed to on March 22, 2019 and ratified by SEIU-UHW members on March 27, 2019. Director Reno seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

Board members expressed their appreciation to both Administration and the SEIU-UHW for their collaborative efforts in reaching agreement in such an expeditious manner. Board member Chavez also commented on the importance of a four-year contract.

b) Consideration to cast the ballot for Regular LAFCO Special District Member

c) Consideration to cast the ballot for Alternate LAFCO Special District Member

Chairperson Grass recognized Mr. Barry Willis, candidate for the Regular LAFCO Special District Member seat. Mr. Willis provided a summary of his background and experience and encouraged the Board to cast their ballot in his favor for the Regular LAFCO District Special Member seat.

Director Nygaard stated that she appreciates Mr. Willis taking the time to come speak before the Board however she has a long-term relationship with candidate Sprague who she feels is very qualified for the position.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors authorize the Board Chairperson to cast the ballot for the Regular and Alternate LAFCO Special District Member Seats as she deems fit. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

15. Old Business - None

16. Chief of Staff

a. Consideration of March 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on March 25, 2019.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors approve the March 2019 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on March 25, 2019. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

17. Consideration of Consent Calendar

It was moved by Director Chavez to approve the Consent Agenda. Director Schallock seconded the motion.

It was moved by Chairperson Grass to pull item 17 (1) b) Patients Injured by Deadly Weapon or Criminal Act Policy 315. Director Schallock seconded the motion.

Director Chavez amended his motion to approve the Consent Agenda minus the item pulled. Director Schallock seconded the motion.

The vote on the amended motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

18. Discussion of items pulled from Consent Calendar

Chairperson Grass who pulled item 17(1) b) Patients Injured by Deadly Weapon or Criminal Act Policy 315 requested information on how our policy coincides with that of the Oceanside and Carlsbad Police Departments.

Mr. Scott Livingstone, COO requested Mr. Jeff Surowiec, Manager of Security and Safety Officer address Chairperson's Grass's question.

Mr. Surowiec explained the weapon would be placed in a sealed bag and locked up. Security Officers are trained to handle such situations and our policies are consistent with that of the OPD and CPD.

It was moved by Director Grass to approve Policy 315 - Patients Injured by Deadly Weapon or Criminal Act. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

19. Reports (Discussion by exception only)

20. Comments by Members of the Public

Chairperson Grass recognized Cathy Cronce, RN who spoke on behalf of the Clinical Practice Council and the California Nurses Association. She commented that union nurses at Tri-City have been holding "meet and greets" to get to know their newly elected officials (Board of Directors) and help them understand nurse's needs and concerns as front line patient advocates. Ms. Cronce stated both employee management relations and patient care topics are being discussed such as an overly punitive environment which has resulted in the loss of excellent nurses, the overuse of Travelers who are not part of the community or vested in long term roles in the hospital, the need to be more environmentally conscious and the need for an RN Resource Pool. Ms. Cronce expressed her appreciation to Board members who have agreed to meet with the Clinical Practice Council and schedule future meetings and encouraged other Directors to respond to their communications and complete their questionnaire.

21. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported in early March Colleen O'Hara was inducted into the San Diego County Women's Hall of Fame and recognized by the entire county of San Diego for all her community efforts. Mr. Dietlin stated Ms. O'Hara was one of the Founders of the Women's Resource Center in Oceanside and also a Foundation Board member for many years.

Mr. Dietlin reported we celebrated Doctor's Day on Wednesday, March 27th. He expressed his appreciation to all the physicians on the Medical Staff for their excellent care and excellent clinical outcomes.

Mr. Dietlin commented on the Auxiliary Scholarship Night which will be held on April 24th. He encouraged everyone to participate in the event and meet tomorrow's healthcare leaders.

Mr. Dietlin expressed his appreciation to Board members for their participation in community events.

Lastly, Mr. Dietlin thanked everyone who was involved in the collective bargaining process. He stated it was the most collaborative bargaining session he has been involved with and congratulated everyone on reaching a "win-win" contract for all parties.

22. Board Communications

Director Younger echoed Mr. Dietlin's comments related to the SEIU-UHW contract and congratulated the bargaining teams on their successful efforts.

Director Coulter did not have any comments.

Director Chavez did not have any comments.

Director Reno congratulated SEIU-UHW and Administration on a successful contract negotiation.

Director Nygaard commented on the collaborative efforts by both SEIU-UHW and Administration and successful contract negotiation.

Director Schallock echoed previous comments related to the contract negotiations.

Director Schallock also commented on the Doctor's Day luncheon which was a very nice event and provided an opportunity for Board members to meet some of the new physicians.

23. Report from Chairperson

Chairperson Grass read a thank you note that was sent to the Board of Directors from former CNE Sharon Schultz who commented that it was an honor to work with the Board for the good of the TCHD community.

In closing, Chairperson Grass congratulated SEIU-UHW and Administration on their successful contract negotiations.

Chairperson Grass extended a Happy Doctor's Day to all our fine physicians.

25. There being no further business Chairperson Grass adjourned the meeting at 4:22 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

April 2, 2019 – 1:00 o'clock p.m.
Assembly Rooms 2&3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at the location noted above at 4002 Vista Way at 1:00 p.m. on April 2, 2019.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director George W. Coulter
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock

Absent was Director Tracy M. Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Anna Aguilar, Senior Director, Human Resources
Susan Bond, General Counsel
Jeff Chang, Counsel, Best Best & Krieger
Dr. Victor Souza, Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 1:00 p.m. in Assembly Rooms 2&3 of the Eugene L. Geil Pavilion at Tri-City Medical Center with attendance as listed above. Director Chavez led the Pledge of Allegiance.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

   It was moved by Director Schallock to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed (6-0-0-1) with Director Younger absent.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Grass made an oral announcement of the items listed on the April 2, 2019 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one matter involving Potential Litigation, one Report Involving Trade

Secrets, Public Employee Evaluation: Board Counsel; and Public Employee Evaluation: Chief Executive Officer.

6. Motion to go into Closed Session

It was moved by Director Reno and seconded by Director Schallock to go into Closed Session at 1:05 p.m. The motion passed (6-0-0-1) with Director Younger absent.

8. Open Session

9. Report from Chairperson on any action taken in Closed Session.

Chairperson Grass reported no action was taken in closed session.

10. Discussion and possible action regarding Employee Benefits Committee

It was moved by Director Nygaard that the Tri-City Healthcare Board of Directors approve Resolution 795, A Resolution of the Tri-City Healthcare District Board of Directors to Rescind the Resolution Adopted on September 25, 2018, that Appointed a New Employee Benefit Plan Committee for the Tri-City Healthcare District Employee Benefit Plans and authorize the CEO to establish the Employee Benefit Plan Committee. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Reno and Schallock**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Younger**

11. Comments by members of the public

There were no comments by members of the public

12. There being no further business, Chairperson Grass adjourned the meeting at 2:20 p.m.

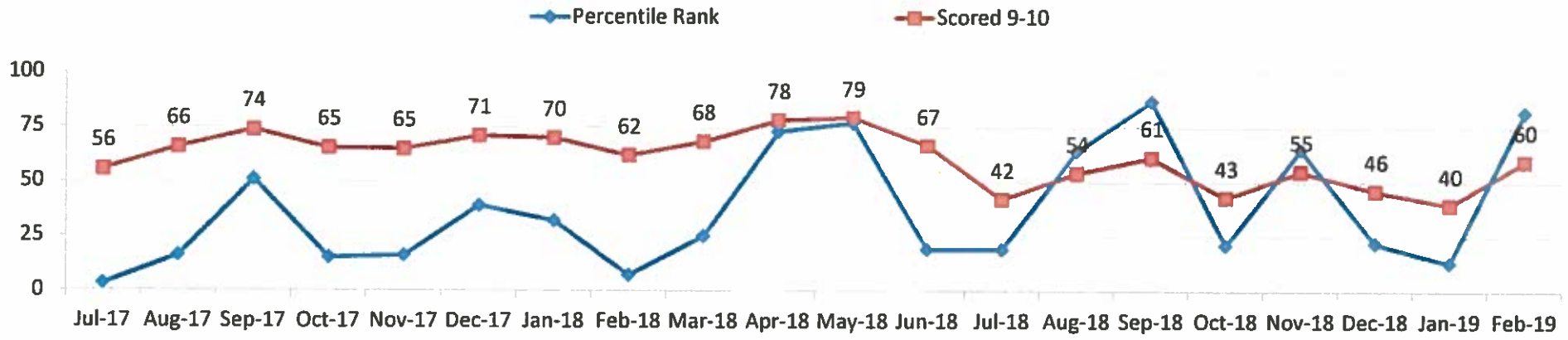
_____
Leigh Anne Grass
Chairperson

ATTEST:

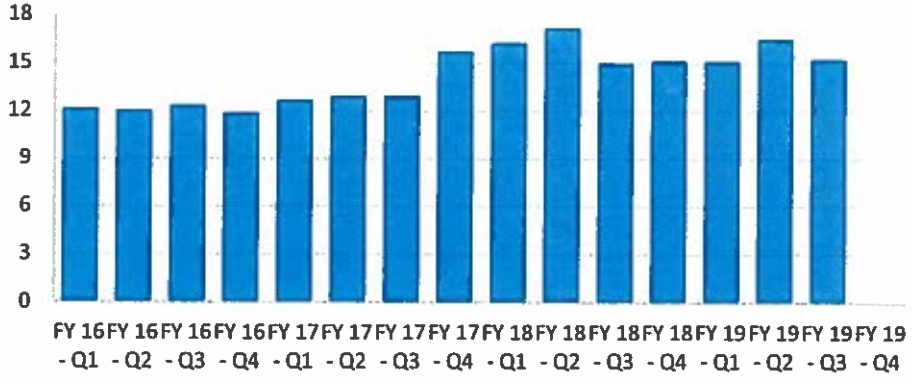
_____
Julie Nygaard
Secretary

Stakeholder Experiences

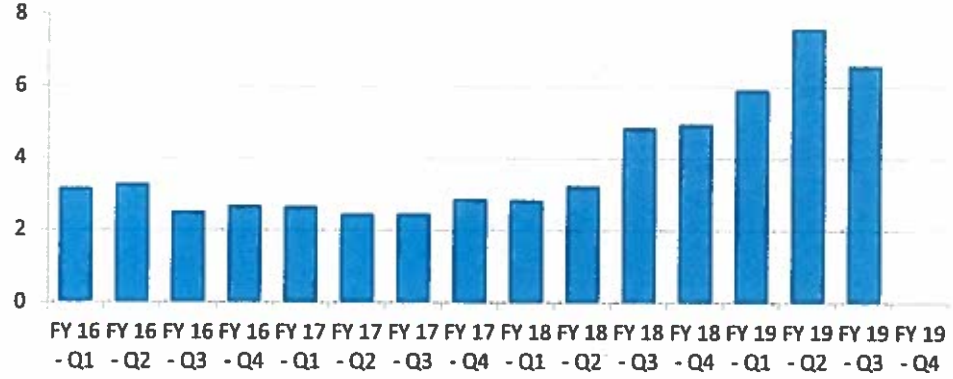
Overall Rating of Hospital (0-10)



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
FY19	18	29	19	27	18	24	22	16	23				196
FY18	26	23	23	20	27	27	22	23	24	20	20	28	215

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY18	10	14	3	7	7	9	10	4	16				80
FY17	14	6	7	13	7	15	14	8	12	7	10	6	96

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	19	16	12	16	12	16	17	13	18				139
FY18	11	12	12	14	16	18	23	12	15	15	16	20	133

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	20	23	18	22	17	21	19	16	18				174
FY18	15	20	20	16	23	15	15	19	23	11	20	17	166

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	31	31	27	35	38	31	23	40	36				292
FY18	48	37	33	32	26	38	29	24	30	38	33	38	297

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
FY19	10.8	11.3	9.7	-	-	-	-	-	-				3.6
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	14.4

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	7.4	9.1	6.5	4.7	5.7	5.3	6.8	8.4	7.2				6.8
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	7.8

Neonatal Intensive Care Unit (NICU) - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	11.4	9.8	10.0	11.0	11.6	8.7	10.1	8.9	11.3				10.3
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	12.9

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	160.3	155.9	146.4	149.6	143.7	153.2	164.8	166.3	157.7				155.3
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	178.3

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	186	202	170	187	185	166	170	150	177				1,593
FY18	210	222	194	206	184	166	209	169	186	156	163	188	1,746

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	10	6	8	3	15	6	9	11				76
FY18	12	11	11	11	11	18	16	5	7	16	15	20	102

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
FY19	3	4	3	13	13	6	11	17	6				76
FY18	4	7	7	3	4	3	2	4	8	2	7	8	42

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	8	8	6	8	4	14	8	10	16				82
FY18	8	7	7	11	3	14	11	10	4	10	8	5	75

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY19	1.79	1.83	1.9	1.78	1.78	1.7	1.72	1.73	1.75				1.77
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	1.76

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	51.0	48.5	50.3	49.5	52.3	56.5	58.9	56.7	57.0				53.4	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	45.8	48.7	

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	86.5	90.2	91.4	92.5	87.8	93.1	92.2	83.6				89.1	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	83.0	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)	($121)	$119	$254	$342	$236	($527)	$99	$206				$130	$2,542
FY18	($394)	($429)	($224)	($171)	($2,571)	($383)	($1,242)	($542)	($337)	($679)	($408)	$3,118	($6,294)	

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%	-0.39%	0.41%	0.86%	1.19%	0.79%	-1.76%	0.34%	0.67%				0.05%	0.97%
FY18	-1.33%	-1.39%	-0.76%	-0.55%	-9.47%	-1.26%	-3.94%	-1.86%	-1.09%	-2.31%	-1.31%	9.07%	-2.33%	

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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	$1,168	$1,417	$1,561	$1,618	$1,544	$826	$1,468	$1,548				$11,946	$14,715
FY18	$898	$864	$1,091	$1,146	($1,288)	$908	$81	$751	$963	$571	$900	$4,407	$5,414	

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%	3.81%	4.90%	5.28%	5.65%	5.20%	2.76%	5.07%	5.00%				4.48%	5.62%
FY18	3.03%	2.80%	3.69%	3.66%	-4.74%	2.99%	0.26%	2.57%	3.13%	1.95%	2.90%	12.82%	2.00%	

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	6.70	6.75	6.98	7.82	6.50	6.68	6.52	6.71				6.82	6.65
FY18	6.51	5.92	6.90	6.26	6.50	6.43	5.95	5.99	5.86	6.29	6.43	6.43	6.24	

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	$49.5	$49.3	$48.1	$37.5	$29.5	$36.3	$32.9	$20.6				
FY18	$58.5	$49.8	$42.3	$48.2	$58.6	$54.5	$54.7	$53.1	$49.4	$42.7	$41.5	$52.8	

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Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases

Month Ending March 31, 2019

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	$1.97	(a)	11,125.74	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)	26,711.35	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	$2.76	(a)	21,313.00	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)	10,272.45	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	$4.24	(a)	26,713.00	10/01/12	10/01/22	**Chemotherapy/Infusion Oncology Center** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056
Total				$182,411.79			

(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 March 2019

Cost Center	Description	Invoice #	Amount	Vendor #	Attendees
7086	ONS/ONCC CHEMOTHERAPY BIOTHERAPY	031619EXP	103.00	13439	ESTELA TERESA BRAGA
8381	INTL ASSOC OF HEALTHCARE	032019EXP	268.00	79820	DEBRA MENDEZ
8390	ASHP 2018 CLINICAL MEETING	111918EXP	934.16	83443	MICHAEL MONTOYA
8440	CALIFORNIA HAZARDOUS WASTE MGMNT WORKSHOP	236350	795.00	82652	JEFF SUROWIEC
8700	CONSENT LAW SEMINAR	031919JENKINS	360.00	14365	NOREEN JENKINS
8710	ARENT FOX LEADERS LAW 2019 CONFERENCE	030119EXP	100.00	83103	SHERRY MILLER
8740	ANIA SD REGIONAL CONFERENCE	030119EDU	100.00	82947	VANESSA VRIENS
8740	CHEMOTHERAPY BIOTHERAPY RENEWAL	032219EDU	103.00	81429	RACHEL CARNER
8740	ACLS RENEWAL	032219EDU	132.00	44920	LYNN MISNER
8740	ACLS RENEWAL	032219EDU	150.00	79442	CHRISTIAN SENERES
8740	UPDATE IN CRITICAL CARE NORTHWEST	032219EDU	151.00	40750	BARBARA MCCANN
8740	ACLS RENEWAL	032219EDU	160.00	48671	NANCY OKUN
8740	2018 BCOP UPDATES COURSE	032219EDU	200.00	18104	ANGELA ANSON
8740	CCRN REVIEW COURSE	030119EDU	200.00	82992	ALLISON MESHAKO
8740	ADULT ECHOCARDIPGRAPHY CME	030119EDU	200.00	83444	ASHLEY O'NEIL
8740	MSN COURSES	022219EDU	5,000.00	81191	JACQUE BENDER
8750	CHA RECORD & DATA RETENTION SCHEDULE	032019EXP2	135.00	83445	AMANDA ABEIN-OVERS
8750	CSHA ATTORNEY ANNUAL MEETING	032019EXP	245.00	83445	AMANDA ABEIN-OVERS
8756	CHA TRANSFORMING VALUE BASED CARE	022719EXP	397.69	83102	JACLYN HUNTER
8758	JOINT COMMISSION HOSPITAL ACCREDIATION	031419EXP	376.60	83225	KELLY WELLS
8790	CHA DISASTER PREPAREDNESS CONFERENCE	032019SUROWIEC	580.00	14365	JEFF SUROWIEC

*This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.

AHA Annual Meeting – April 6-10, 2019
Evaluation
Submitted by Director Rocky Chavez

The conference had two major themes; addressing Disruption in health care and preparation of members for their advocacy on Capitol Hill. Disruption addressed ways hospitals are driving innovation by focusing on the consumer, collaboration, developing partners to disrupt traditional care delivery systems, improving community health and redesigning care delivery. Advocacy focused on affordable, comprehensive health insurance for every American but not supporting "Medicare for All", Protect patients from "Surprise" medical bills, ensure Hospitals have the resources to provide care (I brought brochures for all members of the Board and key members of Tri City Staff).

I was impressed with the caliber of speakers. We heard from Senator Roy Blunt, Congressman Michael Burgess, Robert Costa, Senate Majority Leader Mitch McConnell, John Meacham, Congressman Richard Neal, Speaker Nancy Pelosi, General Colin Powell, Congresswoman Donna Shalala, Ms. Grail Sipes (Deputy Center Director for Regulatory Policy from US Food and Drug Administration), Chuck Todd and Judy Woodruff. Additionally, the panels were made up of experts in their fields from throughout the United States.

I came away with a couple of items I would like to discuss at our strategic meeting. These are: Roles and Responsibilities of Trustees, Trust of Board and CEO, Redefining the "H" in hospital, Virtual Medicine, "Home Care" vs "At Home Care", Healthy Nevada Project (Gene Based Care), Real Time Dashboards to improve ER, Diversity Roundtable to address Health Equity and Social and Cultural environment that impacts health in our Tri City District.

Respectfully Submitted,

Rocky J Chavez