TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
November 12, 2020 – 3:30 o'clock p.m.

In accordance with the current State of Emergency and the Governor's Executive Order N- 25-20, of March 4, 2020, and N-33-20 of March 19, 2020 a virtual platform and/or teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will be able to participate by telephone, using the following dial in information:

Dial in #: (669-900-6833) To Listen and Address the Board when called upon:
Meeting ID: 982 2224 2444; Passcode:343125

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	2 min.	Standard
3	Roll Call / Pledge of Allegiance	3 min.	Standard
4	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 19-018, 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
5	Special Recognition 1) Honoring Directors Julie Nygaard, RoseMarie V. Reno and Larry W. Schallock for their dedication, commitment and service on the Tri-City Healthcare District Board of Directors: ➢ Director Julie Nygaard – 2012 -2020 ➢ Director RoseMarie V. Reno – 1984 - 2020 ➢ Director Larry W. Schallock – 2002 – 2020	10 min.	Chair
6	September 2020 Financial Statement Results	10 min.	CFO

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
7	New Business – a) Fiscal 2020 Financial Statement Audit – Moss Adams b) Consideration to accept the 2020 Fiscal Year Financial Statement Audit	 30 min. 5 min.	 Moss Adams CFO
8	Old Business – None	--	--
9	Chief of Staff a) October 2020 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 26, 2020 – *Information Only*	5 min.	COS
10	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Consideration to approve an agreement with Kaiser Permanente Southern California Graduate Medical Education for a term of 36 months beginning December 1, 2020 through November 30, 2023 for an annual cost of $0 and a total cost for the term of $0. (2) Consideration to approve an agreement with Dr. Richard Smith, Medical Director, Antibiotic Stewardship Program for a term of 24 months, beginning October 1, 2020 through September 30, 2022, not to exceed 24 hours per month or 300 hours annually, at an hourly rate of $175, for an annual cost not to exceed $52,500 and a total cost for the term not to exceed $105,000. (3) Consideration to approve an agreement with Dr. Jeffrey Ferber, Utilization Review/DRG Medical Director for a term of 24 months, beginning November 1, 2020 through October 31, 2022, not to exceed $57,600 and a total cost for the term not to exceed $115,000. (4) Consideration to approve the addition of Arian Nasiri, M.D. to the Interventional Radiology (IR) ED Call Coverage Physician panel for a term of 19 months, beginning December 1, 2020 through June 30, 2022, resulting in no additional increase in cost. (5) Administrative & Board Committees **A. Policies** **1) Patient Care Services Policies & Procedures** a) Hemoglobin using the HemoCue HB 201 Analyzer Procedure (DELETE) b) HMS Plus Hemostasis Management System Procedure c) Influenza Nasopharyngeal Swab Testing Procedure (DELETE) d) Outpatient Specimen Transport to TCMC Main Hospital Laboratory e) Patient Safety in Surgical Areas Policy f) Point of Care Testing Competency Assessment Procedure g) Siemens Rapidpoint Procedure h) Specimen Handling Procedure	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	i) Targeted Temperature Management After Cardiac Arrest j) Urine Chemistry Using a Urine Dipstick Measuring Procedure k) Urine Dipstick Analysis Using Siemens Clintek Status Procedure l) Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure		
	2) Administrative Policies & Procedures a) Parking Program 261		
	3) Unit Specific – Employee Health a) Accident Investigation Procedure 04-06 b) Employee Occupational Accidents or Illnesses c) Ergonomic Policy		
	4) Unit Specific - Engineering a) 9000 Radiation Protection Regulation Guidelines		
	5) Unit Specific – Home Care a) Laboratory Procedures		
	6) Unit Specific – Medical Staff a) Medical Staff Funds & Medical Staff Representation by Legal Counsel		
	7) Unit Specific – Security a) Accountability for Performance of Subordinates #103 (DELETE) b) Aero Medical Transport Responsibilities #223 c) After Action Incident Review and Debriefing 511 d) Arrest and Detention Authority #210 e) Authorized Security Department Uniform and Safety Equipment 401 f) Code Gray – Hostage Response Plan 505 g) Communications #205 h) Computer Usage Policy #228 i) Conflict Resolution #510 j) Delegated Authority #107 k) Department Organization #101 l) Departmental Personnel Issues #307 m) Disaster Plan for Security Department #801 n) Disposal of Drugs and Drug Paraphernalia #506 o) Emergency Department Patient Parking #225 p) Emergency Situation Officer Recall #802 q) Exterior Campus Rounding #227 r) Exterior Door Security #222 s) Fleeing Medical Center Patients #213 t) Hair and Grooming Standards for Security Officers #302 u) Hazardous Materials #513 v) Impounding of Dangerous Weapons #508 w) Key Rings and Security Department Key Control #406 x) Litigation Documentation #701 y) Locker Entry by Force #206 z) Lost and Found Procedures for Security Department #230 aa) Media Relations #229 bb) Medical Center Off-Site Locations #204 cc) Medical Center Power Outage #804		

	Agenda Item	Time Allotted	Requestor
	dd) Missing Patient #212 ee) New Officer Training #301 ff) Patient Stand-By #214 gg) Patient Valuables Collection and Return #237 hh) Patrol of Areas under Construction #226 ii) Personal Safety Escorts for Visitors and Staff #514 jj) Post Positions #202 kk) Preventative Maintenance Program #10 ll) Property Custody #232 mm) Protective Patient Restraints #217 nn) Release of Security Department Reports #108 oo) Retention of Security Department Reports #109 pp) Safety and Security Incident Investigation #233 qq) Search of Property on Medical Center Campus #207 rr) Security Alarm Systems Response #220 ss) Security Department VIP Policy #235 tt) Security Incident Notification #208 uu) Security Management Plan #501 vv) Security Management Plan Attachment #501 (DELETE) ww) Security Officer Documentation #238 (DELETE) xx) Security Panic Alarm System Response #221 yy) Security Protocol for Patient Interaction #211 zz) Security Sensitive Areas #502 aaa) Security Vehicles #405 bbb) Seized Evidence or Contraband #231 ccc) Shift Posts Area of Responsibility #203 (DELETE) ddd) Shift Schedule #201 (DELETE) eee) Span of Control #104 (DELETE) fff) Staff Meetings #105 ggg) Traffic Control in the Event of a Disaster #800 hhh)Unity of Command #102 (DELETE) iii) Unplanned Time Off (Unscheduled Absence/Tardy) #304 (DELETE) jjj)Use of Force #209 kkk) Use of Recording Device #408 lll) Work Overtime #106		
	8) Unit Specific – Surgical Services a) Local Anesthesia in Operating Room Policy		
	9) Audit Compliance & Ethics Policies: a) Privacy Designated Record #514 (DELETE) b) Use and Disclosure of PHI: Records #515 (DELETE) c) Patient Access to Protected Health Information in the Designated Record Set #516 d) Amendment of Protected Health Information #520 e) Use and Disclosure of Information Regarding Media #523 f) Facility Directory and Visiting Guidelines for Clergy #527 g) Accounting of Disclosures of Protected Health Information #528 h) Notification to Pre-Hospital Personnel; Exposure to Infectious Disease #530 i) Sanctions for Non-Compliance with Privacy and Security Policies & Procedures #531 j) Education & Training – Introduction & General Policies #545 k) Education & Training; General Annual Compliance Training Program #547		

	Agenda Item	Time Allotted	Requestor
	l) Education and Training; Specific Training Programs #548 m) Education and Training; Compliance Notices – Updates #550 (DELETE) n) Monitoring Compliance Auditing and Reporting – Exit Interviews #554 o) Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities #556 p) Communicating and Reporting Compliance Concerns (Values Lline) #557 (DELETE) q) Responding to Compliance Issues – Introduction; Reports of Suspected Misconduct; Confidentiality #559 (DELETE) r) Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct #560 s) Responding to Compliance Issues – Reports of Suspected Misconduct Investigation Response #561 t) Responding to Compliance Issues; Remedial Action #562 u) Development and Revision of Code of Conduct and Policies #564 v) Development and Revision of Code of Conduct and Policies – Retiring Code of Conduct and/or Policies #567 (DELETE) w) Referral Source Policies; Contractual Arrangement with Physicians and Other Referral Sources #569 x) Loans and Guarantees to Physicians #571 y) Business Courtesies to Physicians and Immediate Family Members #573 z) Tracking Physician Renumeration and Non-Monetary Compensation #574 (DELETE) aa) HIPAA Administrative Requirements #585 bb) Protected Health Information (PHI) Breach Response #586 cc) Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO) #592 dd) Minimum Necessary Requirements for Use and Disclosure of PHI #594		
	(6) Board Committees		
	A. Community Healthcare Alliance Committee Director Chavez, Committee Chair *(No meeting held in October/November, 2020)*		CHAC Comm.
	B. Finance, Operations & Planning Committee Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in October/November, 2020)*		FO&P Comm.
	C. Audit, Compliance & Ethics Committee Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in October/November, 2020)*		Audit, Comp. & Ethics Comm.
	(7) Minutes – Approval of: a) September 25, 2020, Regular Meeting		Standard
	(8) Meetings and Conferences – None		

	Agenda Item	Time Allotted	Requestor
	(9) Dues and Memberships - a) 2021 California Special Districts Association (CSDA) Membership Renewal - $7,805.00 (10) Reports (a) Construction Report – None (b) Lease Report – (September, 2020) (c) Reimbursement Disclosure Report – (September, 2020) (d) Seminar/Conference Reports – None		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, 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
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1 hour	
17	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
September 9, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 9/25/2020 – 7/31/2022)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 9/25/2020 through 7/31/2022:

- **AZAM, Arsalan MD/Emergency Medicine (TeamHealth)**
- **DESADIER, Jason DO/Emergency Medicine (TeamHealth)**
- **LABBAD, Gabriel MD/OB/GYN (North County Health Services)**
- **LEON, Josue MD/OB/GYN (Vista Community Clinic)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 4
September 9, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 10/01/2020 –9/30/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 10/01/2020 through 9/30/2022, 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:

- **ALLEYNE, Neville, MD/Orthopedic Surgery/Active**
- **BEDROSIAN, Diane, MD/ Pediatrics/Active**
- **COOPERMAN, Andrew, MD/Orthopedic Surgery/Active**
- **CURRY, Jason, MD/Physical Medicine & Rehab/Refer and Follow**
- **DAUGHERTY, David, MD/Orthopedic Surgery/Active**
- **DAVIES, James, MD/Ophthalmology/Active Affiliate**
- **ELLINI, Ahmad, MD/Pediatric Cardiology/Active Affiliate**
- **FERBER, Jeffrey, MD/Family Medicine/Active Affiliate**
- **GLASSER, Judd, MD/Emergency Medicine/Active**
- **GUPTA, Anshu, MD/ Plastic Surgery/Active**
- **IYENGAR, Srinivas, MD/Ophthalmology/Active**
- **KHALESSI, Alexander, MD/Neurological Surgery/Refer and Follow**
- **LIU, Wilson, MD/Family Medicine/Refer and Follow**
- **LOTAN, Roi, MD/Teleradiology/Active Affiliate**
- **PENDLETON, Robert, MD/Ophthalmology/Active**
- **PERRIZO, Nathan, DO/ Pain Medicine/Active**
- **QUESNELL, Tara, DO/Neurology/Active**

Attachment B

- RIAD, Shareef, MD/Teleradiology/Active Affiliate
- SEIDEN, Grant, MD/Orthopedic Surgery/Active
- SHOWAH, Henry, MD/Emergency Medicine/Active
- SLATER, Madeline, MD/Infectious Disease/Active
- TINIO, Stephen, MD/ Family Medicine/Refer and Follow
- ZIERING, Robert, MD/Allergy & Immunology/Active Affiliate
- ZIMMERMANN, Andres, MD/Internal Medicine/Refer and Follow

RESIGNATIONS: (Effective date 9/30/2020 unless otherwise noted)

Automatic:

- WHITNEY, Janet, DO/Wound Care

Voluntary:

- PANZER, Glenn, MD/Hospice & Palliative Medicine
- SAMADY, Joseph, MD/Dermatology
- SMITH, Ryan, DO/Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
September 9, 2020

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **March 31, 2021** would result in these privileges automatically relinquishing.

- **ABBOUD, Jean Paul, MD** — **Ophthalmology**

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given two extensions months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 3 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **December 31, 2020** would result in these privileges automatically relinquishing.

- **AFRA, Robert, MD** — **Orthopedic Surgery**
- **ANTOUN, David, MD** — **Internal Medicine**
- **COHEN, David, MD** — **Cardiology**
- **JAMSHIDI-NEZHAD, Mohammad, DO** — **General and Vascular Surgery**
- **KUSHNARYOV, Anton, MD** — **Otolaryngology**
- **SHIN, Heamin, DPM** — **Podiatric Surgery**

ADDITIONAL PRIVILEGE REQUEST (Effective 9/25/2020)

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

- **SUNTAY, Berk MD** — **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
September 9, 2020

PROCTORING RECOMMENDATIONS

• BIERMAN, Andrew NP	Allied Health Professional
• BROWN, Kaley PAC	Allied Health Professional
• CAMPBELL, Leticia MD	OB/GYN
• KOTAK, Kamal MD	Cardiology
• LANE, Richard MD	Neurology
• LAUFIK, Martin MD	Radiology
• NASIRI, Arian MD	Radiology
• PATEL, Cecil MD	Radiology
• YUNG, Aaron MD	Interventional Cardiology
• ZHANG, Clarice DO	Emergency Medicine

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
October 19, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 10/30/2020 – 07/31/2022)

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 10/30/2020 through 07/31/2022:

- **ALASANTRO, Lori PhD/Allied Health Professional (North County Neurology)**
- **MOMBERG, Jessica CNM/Allied Health Professional (North County Health Services)**
- **ROSEN, Jay PhD/Allied Health Professional (North County Neurology)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 1
October 19, 2020

Attachment B

BIENNIAL REAPPRAISALS: ***None***

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

- Ahumada, Alejandro G., AuD
- Allen, Danielle M., AuD
- Allen, Lindsay, PAC
- Allen, Matthew G., PAC
- Alston, Vickie S., CNM
- Bierman, Andrew, NP
- Bishop, Leslie, NP
- Bratton, Kayla C., PA
- Brockman, Joe B., PA-C
- Brown, Kaley M., PAC
- Brownsberger, Richard N., PAC
- Bulger, Jeffrey, PAC
- Byrd, Kristina C., AuD
- Carlton, Vivian W., PAC
- Carnelian, Alissa A., AuD, CNIM
- Cowan, John W., PAC
- Crespo, Christopher N., PAC
- DeMasco, Michael A., PA
- Eggemeier, Sara, CNM
- Elamparo, Kaye L., NP
- Fazzino, Dolores L., NP, RNFA
- Fisher-Gamez, Lori K., NP, RNFA
- Forbes, Beth, RNFA
- Franz, Cortney D., FNP
- Freiwald, Adam E., PAC
- Frost, Robert, PAC
- Garbaczewski, Stephanie H., PAC
- Guillen, Kathleen R., PA
- Guthrie, Lesli A., AuD
- Haigler, Heather M., PA
- Hamilton Jr., James N., PAC
- Hammonds, Tommy D., PAC
- Heinen, John P., PA
- Hermann, Linda, PAC

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – 1 of 1
October 19, 2020

Attachment B

- Hermanson, Kathleen H., PA
- Huang, Stephanie K., PAC
- Hunt, Cris T., AuD
- Jaramillo, Elizabeth C., AuD
- Jenkins-Sebastiani, Christina L., AuD
- Karver-Christenson, Elyse S., CNM
- Kaur, Manpreet, PAC
- Kelly, Katherine M., CNM
- Kimber, James H., PAC
- King, John F., AuD
- Kolt, Thomas L., PAC
- Kreifeldt, Kimberly A., PAC
- Luu, Jackie, PA
- Martinez, Melinda W., PAC
- Mateo, Marie E., CNM
- McNally, Paul D., NP
- Memeo, Kelly L., NP
- Myers, Shannon E., AuD
- Nguyen, Diana T., CNM
- Perlman, Tamara L., CNM
- Pregerson, Heather A., PAC
- Renne, Brittany A., AuD
- Rice, William M., PAC
- Rivera, Stephen A., PAC
- Savic, Jessica, PA
- Schillinger, Stephan B., PAC
- Schroeder, Mary L., CNM
- Scott, Katie L., PAC
- Stabler, Holly, PAC
- Stenzel, Alison N., PA
- Taylor, Phyllis J., NP
- Tebon, Renee, PAC
- Varner, Alicia N., OT
- Vierra, Erin, NP
- Wallace, Stephanie, PAC
- Weichert, Rachel A., AuD, CNIM
- Winkel, Bradley, PA

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT – Part 3 of 3
October 19, 2020

Attachment C

PROCTORING RECOMMENDATIONS

- **KELLY, Katherine CNM**
  Release from Proctoring:

Allied Health Professional
Certified Nurse Midwife Privileges

TCHD BOARD OF DIRECTORS
DATE OF MEETING: NOVEMBER 12, 2020
KAISER PERMANENTS SOUTHERN CALIFORNIA GRADUATE MEDICAL EDUCATION

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

Vendor's Name: Kaiser Permanente Southern California Graduate Medical Education, representing Kaiser Foundation Hospitals and Southern California Permanente Medical Group

Area of Service: Emergency Department

Term of Agreement: 36 months, Beginning, December 1, 2020 – Ending, November 30, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$0	$0	$0

Description of Services/Supplies:

- The Site Director (TCHD) and other supervising physicians and staff at Participating Site will provide appropriate supervision of the Residents' patient care activities and will maintain a learning environment conducive to educating Residents in the ACGME competency areas
- Duration of Rotation: 2-4 Weeks; PG Level of Rotating Resident:PGY2 and PGY3
- Residents' salaries, benefits, workers' compensation, and malpractice insurance coverage are provided and paid for by Kaiser Foundation Hospital, San Diego
- Resident credentialing paid for and provided by Kaiser Foundation Hospital, San Diego and will coordinate with our Medical Staff Department

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

Person responsible for oversight of agreement: (Candice Parras / Dr. Gene Ma)

Motion:
I move that the TCHD Board of Directors authorize the agreement with Kaiser Permanente Southern California Graduate Medical Education a term of 36 months beginning December 1, 2020 and ending November 30, 2023 for an annual cost of $0 and a total cost for the term of $0.

TCHD BOARD of DIRECTORS
DATE OF MEETING: November 12, 2020
Medical Director Agreement for Antibiotic Stewardship Program

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

Physician's Name: Richard C. Smith, M.D.

Area of Service: Antibiotic Stewardship Program

Term of Agreement: 24 months, Beginning, Oct 1, 2020 – Ending, Sep 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$175	25	300	$4,375	$52,500	$105,000

Position Responsibilities:

- Review inpatient antibiotic orders for appropriateness
- Provide medical direction for the Antibiotic Stewardship Program.

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

Person responsible for oversight of agreement: Michael Montoya, Director, Pharmacy /Scott Livingstone, Chief Operating Officer

Motion:
I move that the TCHD Board of Directors authorize Dr. Richard C. Smith, MD as the Medical Director for Antibiotic Stewardship Program for a term of 24 months, beginning Oct 1, 2020 and ending Sep 30, 2022. Not to exceed 25 hours per month or 300 hours annually, at an hourly rate of $175, for an annual cost not to exceed $52,500, and a total cost for the term not to exceed $105,000.

TCHD BOARD of DIRECTORS
DATE OF MEETING: November 12, 2020
Medical Director Agreement for Utilization Review/DRG Program

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

Physician's Name: Jeffrey Ferber, M.D.

Area of Service: Utilization Review/DRG program

Term of Agreement: 24 months, Beginning, Nov 1, 2020 – Ending, Oct 31, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES *(Verified by MD Ranger)*

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	24 month (Term) Cost Not to Exceed
$160	30	360	$4,800	$57,600	$115,200

Position Responsibilities:

- CMS "Conditions of Participation" and California Title XXII require the Utilization Review (UR) committee ensures DRG program compliance
- Dr. Ferber will be the Medical Director of the UR Committee and he will provide physician input, committee direction and medical staff liaison

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

Person responsible for oversight of agreement: Scott Livingstone, Chief Operating Officer

Motion:
I move that the TCHD Board of Directors authorize Dr. Jeffrey Ferber, MD as the Medical Director for Utilization Review/DRG program for a term of 24 months, beginning November 1, 2020 and ending October 31, 2022. Not to exceed 30 hours per month or 360 hours annually, at an hourly rate of $160, for an annual cost not to exceed $57,600, and a total cost for the term not to exceed $115,200.

TCHD BOARD OF DIRECTORS MEETING
DATE OF MEETING: November 12, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE–Interventional Radiology (IR)

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

Physician's Name: Arian Nasiri, M.D.

Area of Service: Emergency Department On-Call: Interventional Radiology (IR)

Term of Agreement: 19 months, Beginning, December 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
For entire Current ED On-Call Area of Service Coverage: IR
Addition of new physician to current shared call panel; no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$750	FY21:365 FY22:365	$273,750 $273,750
Total Term Cost:		**$547,500**

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Sherry Miller, Manager, Medical Staff Services / Gene, Ma, M.D., Chief Medical Officer

Motion: I move that the Finance, Operations & Planning Committee recommend that the TCHD Board of Directors authorize the addition of Arian Nasiri, M.D. to the Interventional Radiology (IR) ED-Call Coverage Physician panel for a term of 19 months, beginning December 1, 2020 and ending June 30, 2022, resulting in no additional increase in cost.

ADMINISTRATION CONSENT AGENDA
October 26th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Hemoglobin using the HemoCue HB 201 Analyzer Procedure	DELETE	Forward To BOD For Approval
2. HMS Plus Hemostasis Management System Procedure	2 Year Review	Forward To BOD For Approval
3. Influenza Nasopharyngeal Swab Testing Procedure	DELETE	Forward To BOD For Approval
4. Outpatient Specimen Transport to TCMC Main Hospital Laboratory	2 Year Review, Practice Change	Forward To BOD For Approval
5. Patient Safety in Surgical Areas Policy	3 Year Review, Practice Change	Forward To BOD For Approval
6. Point of Care Testing Competency Assessment Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
7. Siemens Rapidpoint Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
8. Specimen Handling Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
9. Targeted Temperature Management After Cardiac Arrest	3 Year Review	Forward To BOD For Approval
10. Urine Chemistry Using a Urine Dipstick Measuring Procedure	2 Year Review	Forward To BOD For Approval
11. Urine Dipstick Analysis Using Siemens Clintek Status Procedure	2 Year Review, Practice Change	Forward To BOD For Approval
12. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure	2 Year Review	Forward To BOD For Approval
Administrative Policies & Procedures/Pay Practices		
1. Parking Program 261	Practice Change	Forward To BOD For Approval
Unit Specific		
Employee Health		
1. Accident Investigation Procedure 04-06	3 Year Review, Practice Change	Forward To BOD For Approval
2. Employee Occupational Accidents or Illnesses	3 Year Review, Practice Change	Forward To BOD For Approval
3. Ergonomic Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Engineering		
1. 9000 Radiation Protection Regulation Guidelines	3 Year Review, Practice Change	Forward To BOD For Approval
Home Care		
1. Laboratory Procedures	3 Year Review, Practice Change	Forward To BOD For Approval
Medical Staff		
1. Medical Staff Funds & Medical Staff Representation by Legal Counsel	NEW	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
October 26th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Security		
1. Accountability for Performance of Subordinates # 103	DELETE	Forward To BOD For Approval
2. Aero Medical Transport Responsibilities #223	3 Year Review, Practice Change	Forward To BOD For Approval
3. After Action Incident Review and Debriefing 511	3 Year Review	Forward To BOD For Approval
4. Arrest and Detention Authority #210	3 Year Review	Forward To BOD For Approval
5. Authorized Security Department Uniform and Safety Equipment 401	3 Year Review, Practice Change	Forward To BOD For Approval
6. Code Gray - Hostage Response Plan 505	3 Year Review	Forward To BOD For Approval
7. Communications #205	3 Year Review	Forward To BOD For Approval
8. Computer Usage Policy #228	3 Year Review	Forward To BOD For Approval
9. Conflict Resolution 510	3 Year Review	Forward To BOD For Approval
10. Delegated Authority #107	3 Year Review, Practice Change	Forward To BOD For Approval
11. Department Organization #101	3 Year Review, Practice Change	Forward To BOD For Approval
12. Departmental Personnel Issues 307	3 Year Review	Forward To BOD For Approval
13. Disaster Plan for Security Department 801	3 Year Review	Forward To BOD For Approval
14. Disposal of Drugs and Drug Paraphernalia 506	3 Year Review	Forward To BOD For Approval
15. Emergency Department Patient Parking #225	3 Year Review	Forward To BOD For Approval
16. Emergency Situation Officer Recall 803	3 Year Review	Forward To BOD For Approval
17. Exterior Campus Rounding 227	3 Year Review	Forward To BOD For Approval
18. Exterior Door Security 222	3 Year Review, Practice Change	Forward To BOD For Approval
19. Fleeing Medical Center Patients #213	3 Year Review, Practice Change	Forward To BOD For Approval
20. Hair and Grooming Standards for Security Officers 302	3 Year Review, Practice Change	Forward To BOD For Approval
21. Hazardous Materials 513	3 Year Review, Practice Change	Forward To BOD For Approval
22. Impounding of Dangerous Weapons 508	3 Year Review, Practice Change	Forward To BOD For Approval
23. Key Rings and Security Department Key Control 406	3 Year Review, Practice Change	Forward To BOD For Approval
24. Litigation Documentation 701	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
October 26th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
25. Locker Entry by Force #206	3 Year Review, Practice Change	Forward To BOD For Approval
26. Lost and Found Procedures for Security Department 230	3 Year Review, Practice Change	Forward To BOD For Approval
27. Media Relations 229	3 Year Review	Forward To BOD For Approval
28. Medical Center Off-Site Locations #204	3 Year Review, Practice Change	Forward To BOD For Approval
29. Medical Center Power Outage 804	3 Year Review	Forward To BOD For Approval
30. Missing Patient #212	3 Year Review	Forward To BOD For Approval
31. New Officer Training 301	3 Year Review, Practice Change	Forward To BOD For Approval
32. Patient Stand-By #214	3 Year Review	Forward To BOD For Approval
33. Patient Valuables Collection and Return #237	3 Year Review	Forward To BOD For Approval
34. Patrol of Areas Under Construction #226	3 Year Review	Forward To BOD For Approval
35. Personal Safety Escorts for Visitors and Staff 514	3 Year Review	Forward To BOD For Approval
36. Post Positions #202	3 Year Review, Practice Change	Forward To BOD For Approval
37. Preventative Maintenance Program #110	3 Year Review	Forward To BOD For Approval
38. Property Custody #232	3 Year Review	Forward To BOD For Approval
39. Protective Patient Restraints #217	3 Year Review, Practice Change	Forward To BOD For Approval
40. Release of Security Dept Information #108	3 Year Review, Practice Change	Forward To BOD For Approval
41. Retention of Security Department Reports #109	3 Year Review	Forward To BOD For Approval
42. Safety and Security Incident Investigation #233	3 Year Review	Forward To BOD For Approval
43. Search of Property on Medical Center Campus #207	3 Year Review, Practice Change	Forward To BOD For Approval
44. Security Alarm Systems Response #220	3 Year Review	Forward To BOD For Approval
45. Security Department VIP Policy #235	3 Year Review	Forward To BOD For Approval
46. Security Incident Notification #208	3 Year Review	Forward To BOD For Approval
47. Security Management Plan 501	3 Year Review	Forward To BOD For Approval
48. Security Management Plan Attachment #501	DELETE	Forward To BOD For Approval
49. Security Officer Documentation 238	DELETE	Forward To BOD

ADMINISTRATION CONSENT AGENDA
October 26th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
		For Approval
50. Security Panic Alarm System Response 221	3 Year Review	Forward To BOD For Approval
51. Security Protocol for Patient Interaction #211	3 Year Review	Forward To BOD For Approval
52. Security Sensitive Areas 502	3 Year Review	Forward To BOD For Approval
53. Security Vehicles 405	3 Year Review	Forward To BOD For Approval
54. Seized Evidence or Contraband #231	3 Year Review, Practice Change	Forward To BOD For Approval
55. Shift Posts Area of Responsibility #203	DELETE	Forward To BOD For Approval
56. Shift Schedule #201	DELETE	Forward To BOD For Approval
57. Span of Control #104	DELETE	Forward To BOD For Approval
58. Staff Meetings #105	3 Year Review, Practice Change	Forward To BOD For Approval
59. Traffic Control in the Event of a Disaster 800	3 Year Review, Practice Change	Forward To BOD For Approval
60. Unity of Command #102	DELETE	Forward To BOD For Approval
61. Unplanned Time Off (Unscheduled Absence / Tardy) 304	DELETE	Forward To BOD For Approval
62. Use of Force #209	3 Year Review, Practice Change	Forward To BOD For Approval
63. Use of Recording Device 408	3 Year Review	Forward To BOD For Approval
64. Work Overtime #106	3 Year Review, Practice Change	Forward To BOD For Approval
Surgical Services		
1. Local Anesthesia in Operating Room Policy	3 Year Review, Practice Change	Forward To BOD For Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HEMOGLOBIN USING THE HEMOCUE 201 DM**
Purpose:	To accurately determine hemoglobin levels at the
Supportive Data:	Hemoglobin testing using the HemoCue meter is federal law. Authorized to perform the procedure: RN, LVN Testing is under the direction, jurisdiction, and responsibility of the Laboratory Director
Equipment:	1 Lancing Device 1 Alcohol pad HemoCue HB 201 Microcuvettes HemoCue Hb 201 DM Analyzer Protective Gloves

DELETE – no longer perform testing

~~A. **ANALYZER OVERVIEW:**~~

~~1. Always slide the analyzer into and out of the docking station by means of the tracks. Never try to lift the analyzer out of or press the analyzer downwards into the docking station. This will damage the casing and power outlets.~~

~~2. The analyzer is powered by a rechargeable battery. When un-docked, the battery can be recharged via the AC adaptor. When docked, the battery is charged via the USB inlet.~~

~~3. A green light from the LED on the docking station indicates that the station is receiving power and the battery is fully charged. A flashing green light indicates the battery is charging.~~

~~4. A steady red light indicated an internal communication error within the docking station. A flashing red light indicates an external communication error. Contact the Laboratory for troubleshooting.~~

~~5. Use only fingertips for pressing the display buttons. Sharp-edged objects can damage the display. Screen responds to the LIFT of the finger.~~

~~6. Refer to Attachment 1 for guide to Display and Function buttons.~~

~~7. When using the barcode scanner, *hold* the barcode scanner button down until the numerical information registers.~~

~~B. **QUALITY CONTROL PROCEDURE:**~~

~~1. The QC Reminder feature will indicate the time when the next QC is due.~~

~~2. Perform two levels of liquid QC each day of testing and upon opening a new vial of microcuvettes. If QC is unsuccessful, QC lockout will be engaged, and the meter will not allow patient testing.~~

~~3. Verify that the control vials are clearly marked with an expiration date and are not expired. Controls are good for 30 days after opening. The laboratory supplies controls. Verify the cuvettes are marked with an open and expiration date and are not expired. Cuvettes are stored at room temperature in a dry place with an operating temperature 15° C to 30° C and relative humidity up to 90%. Cuvettes are good for 3 months after opening. The department orders cuvettes.~~

~~4. Fill the cuvette:~~

~~a. Mix the control solution gently until there is no longer a "ring" on the bottom of the vial when inverted. Do not roll the vial between the palms of your hands. Vials must be mixed properly to assure successful subsequent QC results.~~

~~b. Fill the cuvette directly from the vial or by wicking up a drop from a piece of scotch tape. Wipe the rim and cap with a clean tissue before re-capping.~~

~~c. Wipe excess control from the outer surface of the cuvette. Look for air bubbles in the field of the cuvette. If any air bubbles are present, fill a new cuvette. Small bubbles around the edge can be ignored.~~

~~5. Turn the meter on and enter your User ID (5-digit employee ID number.)~~

Department Review	Clinical Policies & Procedures	Nursing Executive Council	Division of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/12, 12/15, 05/20	10/12, 01/16, 05/20	10/12, 01/16, 06/20	04/18, 09/20	11/12, 04/18, 09/20	10/20	01/13, 05/18, n/a	01/13, 05/18

6. Select QC. Select Level 1.
7. Place the cuvette into the holder and slide the holder into the analyzer.
8. Scan the cuvette batch number.
9. Scan the control lot number (If entered manually, must be 8 digits; i.e. lot GH1161 is entered 00001161.)
10. The result will display along with an interpretation:
    a. Pass: result falls within acceptable limits.
    b. Pass, with warning: result falls within acceptable limits but outside 2SD.
    c. Fail: result falls outside acceptable limits.
11. Enter a comment if necessary (notepad lower left corner).
    a. Opened New Vial (of cuvettes)
    b. Wrong Level; Repeat
    c. Out; Repeat
12. Accept or Reject the measurement.
13. Run the second level: Select QC. Select Level 3.
14. QC must Pass (or Pass, with warning) before continuing with Patient testing. If QC Fails:
    a. Verify the Cuvettes and Control are not expired.
    b. Remove the Cuvette holder and see if there is blood inside the meter (the optics).
    c. Clean the meter if necessary.
    d. Re-mix the control vial and test again.
    e. If controls are still out, contact the Laboratory.

C. **PATIENT TESTING PROCEDURE:**

1. Specimen Collection:
    a. Identify the patient.
    b. Perform a skin puncture.
    c. Wipe away the first 2 or 3 drops of blood with a lint free wipe (do not use cotton balls). Reapply light pressure towards the fingertip until another drop of blood appears.
    d. When the drop is large enough, fill the Cuvette in one continuous process. Do not refill.
    e. Wipe off excess blood from the outer surface of the Cuvette with lint-free tissue. Be careful not to touch the open end of the cuvette.
    f. Look for air bubbles in the filled Cuvette. If any air bubbles are present, fill a new cuvette. Small bubbles around the edge can be ignored.
    g. NOTE: If a second sample is to be taken from the same finger stick, wipe away the remains of the initial sample and fill a second Cuvette from a new drop of blood.
    h. Testing should be completed within 10 minutes of filling the Cuvette.
2. Using the Meter:
    a. Power on the meter and enter your Operator ID with the touch-screen or the barcode scanner.
    b. Select the Patient Test button  .
    c. Place the cuvette into the holder and slide the holder into the analyzer.
    d. Enter the required information:

        i. Patient ID (manually enter , or scan the FIN from the patient's armband)

    e. Verify the entered information.
    f. Results will be displayed in 15-45 seconds. You may:

        i. Add a comment  (to reject the result, add a comment, then select reject)

        ii. Verify the result with another cuvette  . Both results will be displayed along with the mean.

iii. Confirm the result [OK] – the result will remain displayed until the "confirm" button is selected. You may pull out the cuvette holder and inspect the cuvette while the results are still displayed. Accept or reject the result.

D. **REPORTING RESULTS:**
1. Document results on the 24-hour patient flow record.
2. A history of results is stored in the meter and downloaded to the Lab Data Management System for review.

E. **REFERENCE RANGE:**
1. Expected range for hemoglobin:
   Infant: 15.5 – 24.5 g/dL
   Adult: 12.0 – 16.0 g/dL
2. Critical Range
   Infant: ≤ 7.0 g/dL
   Adult: ≤ 7.0 g/dL or ≥ 20.0 g/dL
3. Results above 25.6 g/dL will be displayed as over-range.
4. Results above 20.0 g/dL must be confirmed with a laboratory test.
5. Repeat unexpected results with a new skin puncture or with a lab draw.

F. **PROFICIENCY TESTING PROCEDURE:**
1. Proficiency testing is conducted three times a year. The Laboratory (and Point of Care Program) subscribes to Proficiency Surveys through the College of American Pathologists.
2. Proficiency test samples are to be run in the same manner as patient samples and by personnel who routinely perform patient testing.
3. Select QC.
4. Select Proficiency Test. Fill a cuvette with proficiency testing sample, place it into the cuvette holder, and slide the holder in.
5. Enter the specimen ID.
6. Record the results on the Result sheet provided by the lab.

G. **METER MAINTENANCE:**
1. The Analyzer will perform a Self-Test and Calibration each time it is powered ON.
2. Performed Daily:
   a. Cleaning the Cuvette Holder:
      i. Pull the cuvette holder out to the Loading position.
      ii. Carefully press the small catch positioned in the upper right corner of the Cuvette holder.
      iii. While pressing the catch, carefully rotate the Cuvette holder sideways as far as possible to the left.
      iv. Remove the Cuvette holder from the Analyzer (the holder should slide out easily; if there is some resistance, pull at a different angle) and clean with an alcohol wipe or Sanicloth.
      v. Once the Cuvette holder is completely dry it may be reinserted into the Analyzer.
3. Performed As Needed:
   a. Cleaning the Display:
      i. Make sure that the Analyzer is turned off. The display should be blank.
      ii. Use an alcohol wipe to clean the outer case and glass screen. Wring any excess liquid from wipe before using. Excess liquid may damage the internal workings of the meter and the touch screen. DO NOT use any cleaner other than alcohol on the glass screen.
   b. Cleaning the Optics:
      i. Remove the Cuvette holder.

ii. Use a cotton-tip swab moistened with alcohol or water. Place inside the opening of the optronic unit and swab side to side 5-10 times. If the swab is dirty, repeat with a new swab until cleaning removes no more blood. Wait 15 minutes before replacing the Cuvette holder (the optics must dry).

4. If the meter is not working or displays an error code, contact the Laboratory for troubleshooting and Maintenance.

H. **Resources on Intranet – Clinical Products :**

1. HemoCue Hb 201 DM Analyzer Reference Manual. 901111 040309.
2. HemoCue Hb 201 DM Analyzer Instructions for Use. 901114 140726.
3. HemoCue Hb 201 Microcuvettes Package Insert. Art nr 151712140726.
4. HemoCue Hb 201 Technical letter No 21,June 2012 , GPM287INT_130718
5. HemoCue Hb 201 Performance _ Report, GPM342INT_140415

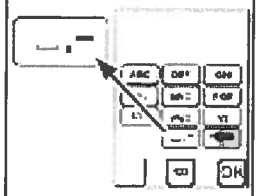
NAVIGATION BUTTONS:

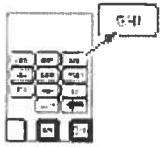
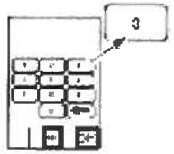
Button	Designation	Function
	Erase button	Erases the last input
	Previous image button	Returns to the previous image NOTE: Inputs/changes made in the current image will not be saved
	Text mode button	Switches to text input mode
	Numeric mode button	Switches to the numeric input mode
	Barcode Scanner button	Switches to the Barcode Scanner mode
	Scroll bar arrow (Up)	Scrolls upwards in a list of different options or in a text
	Scroll bar arrow (Down)	Scrolls downwards in a list of different options or in a text
	Next image button	Continues to the next image in the Help sequence

PROCEDURE BUTTONS:

Button	Designation	Function
	Patient test button	Activates the Patient Test procedure
	STAT test button	Activates the STAT (Short Turn Around Time) Test procedure
	QC test button	Activates the QC (Quality Control) Test procedure
	Stored data button	Activates the Stored Data function
	Settings button	Activates the Settings menu
	Verify button	Allows for the performance of a second test on the same patient, using a new Cuvette, without the need for re-entering the Patient ID and other information
	Comment input button	Allows a comment to be added to the current result
	Comment input button (dotted)	Button appearance confirms that comments have been added to the result

OTHER DISPLAY BUTTONS:

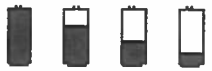
Button	Designation	Function
	Help button	Displays on-line help regarding other buttons, procedures, etc.
	Confirm button	Saves text or numbers and/or displays the next screen image NOTE: All inputs/changes will be saved
	Log Out button	Logs out the operator NOTE: The Log Out button is only displayed if the Operator ID is required.
	Special Character button	Enters a special character (see explanations below) NOTE: Other special characters can only be loaded into the Analyzer by means of the Barcode Scanner.
	See above	Space – press once
	See above	Period – press twice
	See above	Hyphen – press three times
	View button	Provides a more detailed description of the highlighted item

Button	Designation	Function
	Letter buttons	Allows input of a text Example: To enter a "G" – press once To enter an "H" – press twice To enter an "I" – press three times NOTE: Only capital letters will be entered. Lower-case letters can be entered into the Analyzer by means of the Barcode Scanner.
	Digit buttons	Allows input of a digit
	Add button	Allows addition of a comment to a result, an item to a list, etc.
	Delete button	Allows deletion of a comment from a result, an item from a list, etc.
	Accept button	Accepts a measurement
	Reject button	Rejects a result A rejected result will be saved and flagged as rejected

OTHER DISPLAY BUTTONS (CONT.):

Button	Designation	Function
Save	Save button	Stores the entered information
No	No button	The entered information will not be stored.
Continue	Continue button	Continues the current operation
	Statistics button	Displays statistics on the chosen subject
	Date format button	Switches between the following date formats: • YY/MM/DD • DD.MM.YY • MM/DD/YY
	Time format button	Switches between the following time formats: • 12 hours • 24 hours
AM/PM	AM/PM button	Enables adding "AM/PM" (only 12-hour format)

DISPLAY SYMBOLS:

Symbol	Designation	Function
	Battery	Indicates the voltage status of the Battery in four levels. The furthest to the left is fully charged, the one to the right is almost empty.
03/03/04	Date	Indicates the Date format chosen (from three possibilities) in the Settings Menu
	Big Hourglass	The big hourglass is displayed when the Analyzer is in the measuring or selftesting state
	(rotating)	NOTE: The big hourglass is rotating when displayed
	Small hourglass	When the small hourglass is displayed, the instrument is in a measuring or blanking state NOTE: When displayed in the Main Menu, only Settings and Stored Data functions are available. It is also possible to log out
	Waste bin	Indicates that a result has been rejected. The result is stored in the Analyzer.

DISPLAY SYMBOLS (CONT.):

Symbol	Designation	Function
	QC Reminder	Reminder that a QC Test will be required within stated time or number of measurements
	QC Lockout	QC Lockout i.e. no more Patient Test measurements can be made The required QC Test has not been performed.
	Lockout	Supervisory Lockout: The Analyzer has been locked by the Supervisor. A text that indicates this will be displayed.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HMS PLUS HEMOSTASIS MANAGEMENT SYSTEM: ACTIVATED CLOTTING TIME, HEPARIN ASSAY, HEPARIN DOSE RESPONSE**
Purpose:	To monitor heparin management during cardiopulmonary bypass.
Supportive Data:	~~POC Quality Management Manual (Vol. I)~~ **Point of Care Quality Assurance Procedure**
Authorized to Perform:	Perfusionist

A. **DEFINITION:**

1. The Medtronic HMS Plus Hemostasis Management System Operator's Manual has been reviewed and found acceptable to **National Committee for Clinical Laboratory Standards** (NCCLS) standards. Testing should follow manufacturer instructions and recommendations as indicated in the user manual and package inserts. Exceptions or clarifications specific to Tri-City Medical Center are listed in this procedure.

B. **INTRODUCTION/ PRINCIPLE:**

1. The HMS Plus instrument is an integrated system consisting of a component for tracking clot detection and computing results, a component for sample delivery, and the single use test cartridges for actual performance of the tests.
2. The detection process uses the plunger assembly within the cartridge. This assembly is lifted and dropped through the sample/reagent mixture by a lifting mechanism in the HMS Plus actuator. As the sample clots, a fibrin web forms around the daisy, located on the bottom of the plunger assembly, and impedes the rate of decent of the assembly. A photo optical system located in the actuator assembly of the instrument detects this change in fall rate. The end point of the test is the time at which clot formation is detected; from these clotting times, derived results are calculated for all tests.

C. **SPECIMEN:**

1. Fresh whole blood, collected in a 3 mL Monoject syringe that is supplied with the cartridges. Blood may be obtained either by venipuncture or from arterial or venous access lines. See instructions below.
   a. Venipuncture Collection: The venipuncture must be fast, non-traumatic, and the first 2 to 3 ml of blood collected and discarded in a separate syringe in order to prevent contamination of the test sample with tissue activator (thromboplastin) and the potential for erroneous results. Blood should flow quickly into the syringe.
   b. Indwelling Catheter Collection: Flush the line with 5 ml saline, and using separate, single use syringes, collect at least 5 ml or 6 dead space volumes of blood and discard prior to collection of the test sample in order to eliminate the risk of excess dilution and contamination of the sample with heparin from the catheter or line.
2. Minimum sample volumes:
   a.
HDR	3.0 mL
HPT (4 channel)	1.5 mL
HPT (6 channel)	2.5 mL
HPTand HR-ACT	2.5 mL
3. Handling Conditions:
   a. Specimens should be tested as quickly as possible following sample collection.
      i. HDR: within 60 seconds, since the specimen is Unheparinized.
      ii. HPT and HR-ACT: within 60 seconds when there is no anticoagulant on board. Within 2 minutes when sample is heparinized.
      ~~ii.~~

Department Review	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Council~~	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
5/13; 11/15, 05/20	6/13; 12/15, 06/20	6/13, 01/16, 07/20	04/18, 09/20	n/a	7/13, 04/18, 09/20	10/20	8/13, 05/18, n/a	8/13, 05/18

4.**D.** **REAGENTS/SUPPLIES:**

~~a.~~**1.** Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 4-2: Cartridge Design.

~~b. Refer to HMS Plus Operator's manual, section 4-3: Types of Test Cartridges.~~

~~i. HMS Plus Instrument~~

~~ii. Test cartridges~~

~~iii. 3- mL syringes~~

~~iv. 19-gauge 1-7/16-inch blunt needles~~

~~5.~~**2.** ~~Types of Cartridges~~**Refer to HMS Plus Operator's manual, Chapter 4-3: Types of Test Cartridges**

a. Heparin Dose Response (HDR): The HDR is a modified HR-ACT, which measures the *in vitro* anticoagulant response to a known concentration of heparin. This response can be used to evaluate a patient's resistance or sensitivity to heparin. It can also be used to estimate a minimum heparin dose required to achieve a desired target clotting time (HR-ACT).

b. Heparin Assay (HPT): The Heparin Assay test uses the principle of heparin/ protamine titration to quantitatively determine the concentration of heparin in the sample. The heparin concentration determined by the HPT test is used to calculate any additional heparin required to maintain the patient at the [Protocol Hep Conc] entered into the system.

c. Activated Clotting Time (HR-ACT): The HR-ACT is a functional evaluation of the intrinsic coagulation system. It evaluates heparin anticoagulation as well as numerous factors affecting intrinsic clotting.

~~6.~~**3.** Cartridge Preparation:

a. HDR: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed in the heat block of the HMS Plus for at least 3 minutes prior to using.

b. HPT: Gently shake or tap the cartridge before use. Pre-warming of the HPT cartridge is not required.

c. HR-ACT: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed for at least 3 minutes in the heat block of the HMS Plus.

~~7.~~**4.** Precautions:

a. HPT: If the heparin concentration is measured at Channel 1 in a Heparin Assay cartridge that does not have a zero (protamine) in Channel 1, the actual heparin may be lower than the measured value. Similarly, if it is measured in Channel 4 of a four-channel cartridge or Channel 6 of a six-channel cartridge, the actual heparin value may be higher than the measured value. In these cases, another test with a different cartridge (lower or higher as needed) should be run to confirm the result.

b. Regarding Heparin Concentration: see HMS Plus Operators manual 2-~~5~~**6**.

c. Regarding Heparin Dose Response**:** see HMS Plus Operators Manual 2-6.

~~8.~~**5.** Instrumentation/Calibration:

a. Refer to HMS Plus Operator's Manual, ~~section~~ **Chapter** 1: Product Description: Application and Use. Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 3: Installation and Setup. No user Calibration.

~~a.~~

~~9.~~**E.** **QUALITY CONTROL:**

~~a.~~**1.** Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 7: Maintenance and Quality control.

~~b. Refer to Control material Package Insert.~~

~~c. Refer to the Lab generated form: HMS Plus Maintenance Log for current QC requirements.~~

~~d. Indicate completed QC on log.~~

~~e.~~**2.** Liquid quality control must be run:

i. On each new lot/shipment of test cartridges (Refer to ~~Note:~~ New Reagent Lot Validation)

ii. Once per week

~~f.~~**iii.** Electronic quality control must be run each 8 hours of use (once per shift)

~~10.~~**3.** New Reagent Lot Validation.

a. For ACT and HPT cartridges, test liquid controls on new lots/shipments of cartridges before use.
   i. If controls fall within the Manufacturer established ranges, or "pass", the new lot/shipment of cartridges is considered acceptable for use.
b. For HDR cartridges, run a patient on the old and new lots concurrently.
   i. For the new lot of reagent to be considered acceptable for use, the difference in results must be clinically insignificant, as determined by the Perfusionist.
c. Indicate on the "New Reagent Lot Validation Log" that the lot number has been tested and is acceptable for patient use.
d. The laboratory will review control data to ensure that control and patient ranges are similar across different lots of cartridges.

~~11.~~**4.** Notes:
a. Before performing a quality control test, valid lot numbers and expiration dates for both cartridges and controls must be entered. In the case of the HR-ACT controls the ranges for the controls must also be entered.
b. Because controls are produced using prior USP heparin formulation, the heparin type should be set to [Porcine] to run liquid controls. Attempts to run the controls while in the [IU] heparin type setting will result in longer than expected run times for the control test and may produce a failed control result—run times exceeding 249 seconds. (Notice dated 3/8/10).

~~12.~~**5.** Instructions for performing Heparin Assay CONTROLS:
a. Set heparin type:
   i. From main menu, select "instrument parameters"
   ii. Select "heparin type"
   iii. Toggle to [porcine]
   iv. Press "enter" to confirm selection
   v. Perform QC testing
b. Quality control records are maintained in the instrument and periodically downloaded and reviewed by the Laboratory designee.

~~D.~~ QC RANGES HEPARIN ASSAY:

Four-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Red/Yellow	0.0 – 0.9 RED	4	< 249 sec
Red/Yellow	0.0 – 1.5 YELLOW	3 or 4	< 249 sec
Tan/Silver	1.5 – 3.0 TAN	4	< 249 sec
Tan/Silver	2.0 – 3.5 SILVER	3 or 4	< 249 sec
Blue/Gold	2.5 – 4.0 BLUE	3 or 4	< 249 sec
Green/White	3.5 – 5.0 GREEN	3 or 4	< 249 sec
Purple/Black	4.5 – 6.0 PURPLE	3 or 4	< 249 sec

Six-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Orange	0.0 – 2.5 ORANGE	5 or 6	< 249 sec
Blue/Gold	1.5 – 4.0 GOLD	5 or 6	< 249 sec
Green/White	2.5 – 5.0 WHITE	5 or 6	< 249 sec
Purple/Black	3.5 – 6.0 BLACK	5 or 6	< 249 sec

~~E.~~ **QC RANGES** HR-Act:

Ranges will change lot to lot—refer to the package insert.	
CLOTtrac HR Normal	75 – 115
CLOTtrac HR Abnormal	270 – 710

F. **MAINTENANCE:**

1. Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 7: Maintenance and Quality control.
   a. To be completed monthly:
      i. Verify dispenser volume delivery
      ii. Verify heat block temperature
   b. To be completed routinely:
      i. Clean the instrument case and exposed surfaces of the actuator and dispenser of dust and dried blood
      ii. Clean/ Replace salvage reservoir (located under the dispenser).
   c. Maintenance is recorded on the Lab generated form: HMS Plus Maintenance Log.
   d. Discard all the completed testing materials and controls in the provided and appropriate waste containers.

G. **PROCEDURE:**

1. Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 5: Operating Instructions.
   a. Note: Users of the HMS Plus must be aware of which type of heparin is being administered and configure the HMS Plus appropriately. Due to the change in potency, when NEW USP heparin is used, the HMS instrument "heparin type" must be set to "IU" to ensure correct blood dispensing and calculations of results. (Notice dated 12/19/09)
   b. Instructions for performing HPT and HDR PATIENT tests with new USP Heparin:
   c. Set heparin type:
      i. From main menu, select "instrument parameters"
      ii. Select "heparin type"
      iii. Toggle to [iu]
      iv. Press "enter" to confirm selection
      v. Perform qc testing

H. **CALCULATIONS:**

1. Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** ~~4-11~~**10**: Calculations.
   a. Blood Volume Calculations
   b. Heparin Dose Response Calculations
   c. Heparin Bolus Dose Calculations
   d. Heparin Assay Calculations

I. **TECHNICAL NOTES:**

1. Refer to HMS Plus Operator's manual ~~section~~ **Chapter** 2: Warnings and Operational Precautions.

J. **LIMITATIONS:**

1. Refer to HMS Plus Operator's manual, ~~section~~ **Chapter** 2: Warnings and Operational Precautions.
2. Difficulty in collection of the sample for testing may result in activation and erroneous results. If the test results do not correlate with the patient's clinical picture the test should be repeated on a new sample.

K. **REPORTING RESULTS:**

1. Results are recorded in the patient medical record.
2. POCC evaluates held up patients' results that are pending to post on patients' charts whenever needed.

L. **FORM (S):**

~~1. ACT/HMS Plus New Lot Acceptability Testing Log~~
~~2.~~**1.** ACT/HMS Plus New Reagent Lot Validation Log
~~3. ACT/HMS Plus Troubleshooting Log~~
~~4.~~**2.** HMS Plus Maintenance Log

M. **REFERENCE(S):**

1. Medtronic~~.~~ HMS Plus ~~Version 4.0~~ Hemostasis Management System Operator's Manual. ~~2005~~**2012 Rev. 1C**
2. Medtronic. HEPtrac™ Electronic Quality Control Operator's Manual, 1998.
3. Medtronic. Heparin Assay Cartridges. Package Insert. 2004. A10740001-02.
4. Medtronic. Heparin Assay Controls. Package Insert. 2004. A08717001-01.
5. Medtronic. HR-ACT Cartridges. Package Insert. 2003. UC200402200ML.
6. Medtronic. HR-ACT Controls. Package Insert. 2004. A08718003-01.
7. Medtronic. Heparin Dose Response Cartridges. Package Insert.
8. NCCLS Point-of-Care In Vitro Diagnostic (IVD) Testing; Approved Guideline, AST2-A, Volume 19, Number 9, June 1999.
9. HMS Plus Individualized Quality Control Plan (IQCP) ~~in Point of Care/Lab binder.~~

ACT HMS NEW REAGENT LOT VALIDATION LOG

Unit:	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Two levels of liquid control must pass manufacturer established ranges to be acceptable for use. Instructions: Before a new lot of test cartridges is placed into use, perform QC abnormal and normal on each lot. Indicate on this log 1.) if QC passes, and 2.) if the lot of cartridges is acceptable for use. If QC fails, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.
☐ **CATH LAB** (1002009) ☐ **OR 6** (9001585) ☐ **OR 5** (9001456)	

CARTRIDGE: **ACT-HR**

Date	New Lot		QC Normal	QC Abnormal	Ok for Use? (Yes/ Initial)
	Lot	Exp	Pass? (Yes or ✓) (If No, indicate any corrective action taken)		
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/
					/

CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

ACT HMS NEW REAGENT LOT VALIDATION LOG

☐ **OR6** (9001585) ☐ **OR5** (9001456)	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Instructions: Before a new lot of test cartridges is placed into use, perform a patient test concurrently on the new lot and previous lot in use. Indicate on this log 1.) if the difference between results is clinically insignificant, and 2.) if the lot of cartridges is acceptable for use. If the difference is clinically significant, or for any reason causes concern, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.

CARTRIDGE: **HDR**

Date	New Lot		Patient: Proj Hep Concent.			Ok for Use? (Yes/ Initial)
	Lot	Exp	Prev Lot	New Lot	Clinically Insignificant ? (Yes or ✓)	
						/
						/
						/
						/
						/
						/
						/
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						/
						/
						/
						/

CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

ACT / HMS NEW REAGENT LOT VALIDATION LOG

☐ **OR6** (9001585) ☐ **OR5** (9001456)	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Liquid control must pass manufacturer established ranges to be acceptable for use. Instructions: Before a new lot of test cartridges is placed into use, perform QC on each lot. Indicate on this log 1.) if QC passes, and 2.) if the lot of cartridges is acceptable for use. If QC fails, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.

CARTRIDGE: **HPT {R=RED} {T=TAN} {S=SILVER} {B=BLUE} {G=GREEN}**

Date	New Lot			QC		Ok for Use? (Yes/ Initial)
	Color	Lot	Exp	Hep Test Conc.	Pass? (Yes or ✓) (If No, indicate any corrective action taken)	
						/
						/
						/
						/
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						/

CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

HMS PLUS MAINTENANCE LOG

☐ **OR6** (9001585)
☐ **OR5** (9001456)

Purpose: To provide documentation of regular maintenance and cleaning of instruments.
Note: Daily QC records are maintained in the instrument DM system—user lockout will engage if QC has not been successfully completed.
Instructions: Record monthly maintenance on this log. Document problems and corrective actions below.
Records will be reviewed by the Laboratory designee and stored in the lab.

Year	Month	Routine Cleaning (exposed surfaces/ salvage reservoir)		Verify Heat Block Temperature		Verify Dispenser Volume Delivery		Review (Lab use)
		Date	Operator	Date	Operator	Date	Operator	
20___	January							
	February							
	March							
	April							
	May							
	Jun							
	July							
	August							
	September							
	October							
	November							
	December							

DATE	PROBLEM	CORRECTIVE ACTION	REVIEW

Tri-City Medical Center	Distribution:

DELETE – follow Online Skills Specimen Collection: Nose and Throat

PROCEDURE:	**INFLUENZA NASOPHARYNGEAL SWAB TEST**
Purpose:	To provide guidelines for Registered Nurses and L… patients for influenza. Patients requiring influenza testing will have nasopharyngeal swabs obtained in a timely manner using technique which will assure accurate results.
Equipment:	Dacron-tipped nasopharyngeal swab with flexible wire handle Mask Goggles or face shield Gloves and gown Tissues

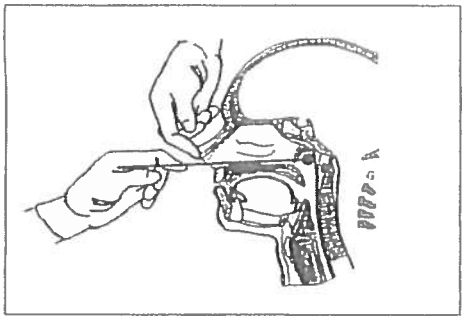
~~A. **OBTAINING SPECIMEN:**~~

~~1. Don personal protective equipment.~~

~~2. Have patient sit with head against wall as patients have a tendency to pull away during this procedure.~~

~~3. Insert swab into one nostril~~ **straight back** ~~(not upwards) along the floor of the nasal passage for several centimeters until reaching the posterior wall of the nasopharynx (resistance will be met). The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not force the swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.~~

~~4. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.~~



~~B. **TRANSPORT TO LAB:**~~

1. ~~Specimen must be transported to the lab as soon as possible.~~

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/12, 06/16, 10/18, 05/20	12/12, 07/16, 11/18, 05/20	12/12, 07/16, 06/20	09/20	n/a	01/13, 08/16, 09/20	10/20	02/13, 09/16, n/a	02/13, 09/16

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/13

SUBJECT: ~~Outpatient~~ **Specimen Transport to TCMC Main Hospital Laboratory from Off-Site Facilities**

REVISION DATE(S): 4/2020

Patient Care Services Content Expert~~Department~~ Approval	**~~11/16~~03/20**
Clinical Policies and Procedures Approval:	**~~03/17~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~03/17~~06/20**
Department of Pathology Approval:	**~~08/17~~09/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/17~~09/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~10/17~~ n/a**
Board of Directors Approval:	**10/17**

A. **PURPOSE:**

1. To protect the integrity of all laboratory specimens and to ensure accuracy of results, specimens collected at **off-site facilities**~~the Center~~ must be transported in a timely manner as mandated by the hospital's laboratory policies.

B. **POLICY:**

1. All specimens will be delivered to the laboratory as prescribed by laboratory policy.
2. In the event that a specimen cannot be transported in the prescribed time period, the laboratory will be contacted for assistance to accomplish transport.

C. **PROCEDURE:**

1. When collecting specimens, clinic staff will wear, at a minimum, exam gloves. If soiling or splattering is likely, the proper personal protective equipment will be utilized during the specimen collection procedure.
2. All specimens are collected following specific laboratory procedures.
3. Labeling
   a. Refer to the Patient Care Services Specimen Labeling Procedure
4. Specimens will be placed in plastic sealed biohazard bags with ~~an outside pouch to secure~~ the appropriate request form **secured to the outside**.
5. Specimens will be brought to the laboratory within the timeframe designated by the hospital laboratory.
6. ~~If the outpatient facility cannot deliver the specimen in a timely manner, the laboratory will be contacted for assistance.~~
7. **~~7.~~6.** The laboratory will notify the clinic when specimens are not acceptable.
   a. The clinician will notify the physician for further orders.

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

1. Patient Care Services: Specimen Labeling Procedure

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY~~

ISSUE DATE: 4/94	**SUBJECT:** Patient Safety in Surgical/Procedural Areas
REVISION DATE: 7/13; 01/14, 03/16	**POLICY NUMBER:** IV.VV

Patient Care Services Content Expert:	03/20
Clinical Policies & Procedures Committee Approval:	~~11/15~~04/20
Nursing Leadership~~Executive~~ Committee:	~~12/15~~05/20
Operating Room Committee	~~02/16~~06/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/16~~09/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~03/16~~ n/a
Board of Directors Approval:	03/16

A. **PURPOSE:**

1. To provide guidelines for the implementation of safe care to patients and assist in the identification of potential hazards.

B. **POLICY:**

1. Potential hazards associated with controlling the patient's temperature shall be identified, and safe practices shall be established.
   a. When assessing the need for devices to monitor and/or control patient temperature, the following factors shall be considered **in collaboration with the perioperative team members (i.e., Anesthesiologist, Surgeon, Perioperative Registered Nurse [RN]), according to AORN Guidelines for Perioperative Practice**:
      i. Patient's age
      ii. Patient's physical status
      iii. Type of anesthesia used
      iv. Ambient room temperature
      v. Length and type of surgical procedure
      vi. Patient positioning
      ~~v.~~**vii. Warming equipment constraints or potential for adverse events associated with use of warming equipment.**
   b. Maintenance of optimum patient temperature shall begin in the preoperative phase and continue into the postoperative phase. Perioperative nursing interventions include, but are not limited to:
      i. Applying forced air pre-warming gown and device in pre-operative area
      ii. Applying warm blankets to the patient on his/her arrival to the surgical area, and after sterile drapes have been removed
      iii. Limiting the amount of patient skin surface exposure during positioning and skin preparation ~~(alcohol-based preps must be allowed a minimum of 3 minutes to dry before draping)~~
      iv. Limiting the time between skin prepping and surgical draping **(Note: alcohol-based preps must be allowed a minimum of 3 minutes to dry before draping)**
      v. Preventing surgical drapes from becoming wet, if possible
      vi. ~~Adjusting~~ **Increasing** the **ambient** room temperature
      vii. Using heat/cooling maintenance devices intraoperatively

viii. Providing surgical team members with warmed/cooled irrigation/infusion solutions as necessary

c. Temperature regulating devices shall be used according to manufacturer's recommendations.
   i. Forced air warming devices must only be used with the manufacturer recommended blanket/gown. "Hosing," or applying the hose of the forced air warming device directly under blankets or drapes, is not allowed.
   ii. Direct patient skin contact with plastic surfaces (for example Hosing) of temperature regulating blankets/gowns shall be avoided.
   iii. Folds and creases in temperature regulating blankets/gowns shall be avoided.
   iv. Do not allow the hose of the forced air warming device to contact the patient, even when using the properly attached gown or blanket. Maintain adequate tension on the hose to keep it from touching the patient.
   ~~iv.~~**v. When using a forced air warming blanket with a head drape, arrange the drape in a manner that allows the air to flow freely from under the drape, and keep the blower activated while the drape is in place.**

d. Temperature regulating devices shall be assigned identification numbers (or use the serial numbers) and documented in the OR Record.

e. Skin integrity shall be inspected before, periodically during (if possible), and after the use of temperature regulating devices.

f. Irrigation/infusion solutions shall be warmed / cooled to temperatures appropriate for the surgical needs and according to manufacturer's recommendations.
   i. Microwave ovens/autoclaves shall not be used to warm solutions.

2. Potential hazards associated with chemicals used in surgery/**procedural areas** shall be identified, and safe practices shall be established for their use.
   a. Personnel shall be informed of the hazards associated with the chemicals used in their practice setting.
   b. Safety Data Sheets (SDS) shall be accessible within the practice setting.
   c. The mixing/combining of chemicals shall be avoided unless safe outcomes can be ensured.
   d. Decanting or transferring of solutions/chemicals from the primary container to another container should be avoided unless no other option exists or the solution/chemical is intended to be decanted.
      i. Containers used for decanted solutions must be labeled with all appropriate and necessary product information including name, strength, uses, precautions and SDS information.

3. Potential hazards associated with the use of electrical equipment in surgery/**procedural areas** shall be identified, and safe practices established.
   a. All electrical equipment shall be inspected before use, including but not limited to:
      i. Checking power outlet and switch plates for damage
      ii. Checking power cords and plugs for fraying or other damage
      iii. Biomedical or electrical safety inspections of all new, rented, leased, or borrowed equipment before it is placed in the practice setting
   b. Equipment cord length shall be appropriate for the intended use of the item:
      i. Extension cords shall not be used in the surgical setting
      ii. Power strips may be used in the surgical setting under the following conditions:
         1) Only use hospital-grade power strips which have been approved by Clinical Engineering and Biomed departments
         2) Do not exceed 75% of the power strip capacity
   c. Line isolation monitoring systems or ground fault interrupting systems shall provide continuous monitoring of electrical current leakage.
   d. Any malfunctioning electrical equipment shall be immediately removed from use:
      i. Equipment failures which involve potential injury, injury or death to a patient will be secured, investigated and reported in accordance with Local, State and Federal Regulations.

ii. These incidents shall be immediately reported to the Charge Nurse, Supervisor, Biomedical Engineering, Safety Officer and Risk Management.

4. Potential environmental hazards that affect patient care shall be identified, and safe practices shall be established.
   a. The use of medical gases in the surgical area shall meet all established regulations and standards including, but not limited to:
      i. No flammable gases shall be used in the surgical area
      ii. All free standing gas cylinders shall be properly chained for support or in a portable holder or storage container
      iii. All anesthesia machines and related equipment shall be constructed so that connections for different gases are not interchangeable
      iv. Staff members shall demonstrate knowledge concerning the use, handling, storage, and disposal of gas cylinders
      v. Cylinders shall be stored in designated locations, in a quantity allowed by policy
   b. The number of air exchanges per hour, temperature, and humidity in anesthetizing locations shall meet the established regulations and standards (California Code of Regulations Title 24).
      i. Temperature and relative humidity levels in anesthetizing locations are maintained and tracked by Plant Operations.
         1) The Building Management System shall be programmed to track and record the relative humidity levels continuously and alert the duty plant engineer if the humidity drops below 20%.
         2) Plant engineering staff shall take corrective action and notify Surgery department **and procedural areas** when relative humidity drops below 20%.
         ~~3) Temperature/humidity monitors are located in each OR for staff reference.~~
         ~~4) Batteries on the OR temperature/humidity monitors will be changed every 6 months.~~
      ii. When notified by Plant Operations that temperature or humidity are out of range, the Engineering Department (high or low temperature or humidity) are consulted to determine appropriate actions.
      ~~iii. Cases in progress will be completed, and the OR room will be closed for use until notified by Engineering that humidity is within acceptable range.~~
      ~~iv.~~**iii.** The use of portable humidifiers or dehumidifiers in the OR is not permitted.
   c. Floors shall be clean, dry, unobstructed, and in good repair.
   d. Lighting shall be adequate for:
      i. Illuminating the surgical field
      ii. Monitoring the patient
      iii. Performing perioperative duties
5. Isolation techniques for preventing the transmission of infectious agents shall be identified and established.
   a. Specific techniques shall relate to the risk levels of the infectious agents and be developed in conjunction with Infection Control practitioners using the Centers for Disease Control and Prevention guidelines and other appropriate agencies.

C. **REFERENCES:**

1. California Code of Regulations Title 24
2. **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**
3. **ASHRAE Technical Committee 9.6, Healthcare Facilities. (2019). *Humidity Control Events in Perioperative Care Areas.* www.ashrae.org.**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**POINT OF CARE TESTING COMPETENCY ASSESSMENT**
Purpose:	To outline the mandatory Point of Care testing personnel competency requirements.
Supportive Data:	To meet regulatory requirements, to include but not limited to College of American Pathology and Joint Commission

A. POLICY:

1. Point of Care Testing (POCT) includes analytical patient tests performed outside the clinical facilities of the main laboratory. All POCT is covered under the Laboratory's Clinical Lab Improvements Amendments license, and is subject to the same regulations. The College of American Pathologist (CAP) personnel competency requirements for POCT includes:
   a. Evidence testing personnel have adequate, specific training to ensure competence.
   b. A list delineating the specific tests each POCT personnel is authorized to perform.
   c. A documented program ensuring each person performing POCT maintains satisfactory levels of competence.
2. Joint Commission requires competency to be assessed using at least two (2) of the following methods per person per test:
   a. Performance of a test on a blind specimen.
   b. Periodic observation of routine work by the supervisor or qualified designee.
   c. Monitoring of each user's quality control performance.
   d. Use of written test specific to the test assessed.
3. Competency for waived testing shall be evaluated upon hire and annually thereafter. Competency for non-waived testing shall be evaluated upon hire, semi-annually during the first year, and annually thereafter. Competency shall be reassessed at any time when problems are identified with employee performance.
4. The records must make it possible for the Inspector to determine what skills were assessed and how those skills were measured. Some elements of competency include, but are not limited to:
   a. Direct observations of routine patient test performance, including, as applicable, patient identification and preparation; and specimen collection, handling, processing and testing.
   b. Monitoring the recording and reporting of test results, including, as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records.
   d. Direct observation of performance of instrument maintenance and function checks, as applicable.
   e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples.
   f. Evaluation of problem solving skills.
5. For non-waived (moderate-complexity) tests, all of the above six (6) elements must be assessed ~~annually~~. For waived tests, it is not necessary to assess all elements at each assessment. Ongoing supervisory review is an acceptable method of assessing competency.
6. Personnel will not be allowed to perform POC testing without completion of the competency requirements.

B. PROCEDURE:

1. The Laboratory Medical Director authorizes personnel to perform testing. Authorization is determined by job description and is specific to nursing unit and job title. Refer to the Laboratory Point of Care Coordinator and Quality Management Manual for any clarification.
2. Evidence of training and competency shall be documented and records shall be maintained in the Employee file.

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Department of Pathology	Pharmacy ~~and~~& Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 06/14, 10/17	04/11, 06/14, 11/17, **06/20**	05/11, 06/14, 12/17, **07/20**	08/14, 04/18	n/a	n/a	**10/20**	06/11, 10/14, 04/18, **n/s**	06/11, 11/14, 04/18

3. Management is responsible to ensure all testing personnel within their department have completed the required competencies.
4. If an individual fails to complete competency assessment by the due date, they will not be allowed to perform POC testing until the competency is completed.
5. ~~Return all completed competencies to the Education department.~~
   ~~**Electronic forms are completed thru NetLearning for Competency Assessment and Learning Modules**~~
   a. ~~**Paper based**Blank forms are found on the TCMC Intranet.~~

C. **FORM(S):**

1. Point of Care Competency **Assignments Summary – Job Description**~~Form~~

D. **REFERENCE(S):**

1. College of American Pathology. (~~2014~~**2019**) Point of Care Testing Checklist.
2. e-dition.jcrinc.com WT.03.01.01. Retrieved on May 11, 2011.
3. The Joint Commission (2017). *Hospital Accreditation Standards*. Illinois: Joint Commission Resources.

POC COMPETENCY ASSIGNMENTS SUMMARY-Job Description

Unit / Job Description		Competencies to Complete:						
		Waived				*Non-Waived*		
		Glucose	INR	Nitrazine	Urine Dipstik	ACT/ HMS	Blood Gas	ROM
1N Ortho	RN	X						
1S Rehab	RN	X						
2P ONC	RN	X						
4P MMU	RN	X						
Cardiac Rehab TCMC/WC	RN, EXC PHYS.	X						
Cath Lab	RN					X	X	
	CVT, X-ray Tech					X	X	
ED	RN	X						
Forensics, IP	RN	X						
Home Care	RN, LVN	X	X					
ICU	RN	X						
Interventional Radiology	RN	X						
	Spec Proc Tech	X						
NICU	RN	X						
PACU	RN	X					X	
Pre-Op Hold	RN	X						
Primary Care Clinic	Phlebotomist		X					
Pulm. Rehab	RCP	X						
Respiratory	RCP						X	
Surgery OR	RN	X					X	
	Perfusionist					X	X	
	Anesth. Tech						X	
Tele	RN	X						
WCS: L&D	RN	X		X	X			X
WCS: PP, 2S	RN	X						
WCS: Nursery	RN	X						
Wound Care	RN, LVN, MA	X						

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SIEMENS-RAPIDPOINT ® 500**
Purpose:	The analysis of blood gases, electrolytes, ionized calcium, glucose, and hematocrit.
Supportive Data:	**Siemens RAPIDPoint ® 500 Operator's Guide** ~~The Rapidpoint 500 system uses potentiometry, amperometry, and conductance to measure the concentration of analyte in the sample. An electrochemical interaction between the analyte of interest and the sensor generates an electrochemical signal that is proportional to the amount of analyte in the sample. Potentiometry is the technology that measures the difference/ potential between two electrodes in a solution without applied current. Amperometry involves applying voltage to an electrode and then measuring the current generated. Conductance is the readiness with which a conducting substance transmits electrical current.~~
Equipment:	~~Rapidpoint 500~~**RAPIDPoint ® 500** Analyzer ~~Syringe or Capillary Tube~~
Authorized to Perform Procedure:	Registered Nurse (RN), Respiratory Care Practitioner (RCP), Perfusionist, Anesthesia Technician, Clinical Laboratory Scientist (CLS)
NOTE:	For more detailed information regarding technology, reagents, calibration points, etc., please refer to the laboratory and/or manufacturer's user manual.

A. **~~CLINICAL SIGNIFICANCE:~~PRINCIPLE:**

1. **The RAPIDPoint ® 500 system uses potentiometry, amperometry, and conductance to measure the concentration of analyte in the sample. An electrochemical interaction between the analyte of interest and the sensor generates an electrochemical signal that is proportional to the amount of analyte in the sample. Potentiometry is the technology that measures the difference/ potential between two electrodes in a solution without applied current. Amperometry involves applying voltage to an electrode and then measuring the current generated. Conductance is the readiness with which a conducting substance transmits electrical current.**

B. **CLINICAL SIGNIFICANCE:**

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
SODIUM	Dehydration Diabetes insipidus Salt poisoning Skin losses Hyperaldosteronism CNS disorders	Dilutional hyponatremia (cirrhosis) Depletional hyponatremia Syndrome of inappropriate ADH
POTASSIUM	Renal glomerular disease Adrenocortical insufficiency Diabetic Ketoacidosis (DKA) Sepsis In vitro hemolysis	Renal tubular disease Hyperaldosteronism Treatment of DKA Hyperinsulinism Metabolic alkalosis Diuretic therapy
CHLORIDE	Prolonged diarrhea Renal tubular disease Hyperparathyroidism	Prolonged vomiting Burns Salt-losing renal disease

Patient Care Services Content Review	Clinical Policies & Procedures Committee	Nursing Leadership~~E xecutive Council~~	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/09, 05/15, 04/18, **06/20**	07/11, 05/15, 05/18, **07/20**	08/11, 05/15, 05/18, **08/20**	03/16, **06/18, 09/20**	n/a	10/11, 04/16, 06/18, **09/20**	**10/20**	11/11, 05/16, 07/18, **n/a**	11/11, 05/16, 07/18

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
	Dehydration	Overhydration Thiazide therapy
IONIZED CALCIUM	Dehydration Hyperparathyroidism Malignancies Immobilization Thiazide diuretics Vitamin D intoxication	Hypoparathyroidism Early neonatal hypocalcemia Chronic renal disease Pancreatitis Massive blood transfusions Severe malnutrition
GLUCOSE **GLUCOSE**	Diabetes mellitus Pancreatitis Endocrine disorders (e.g. Cushing's syndrome) Drugs (e.g. steroids, thyrotoxicosis) Chronic renal failure Stress IV glucose infusion	Insulinoma Adrenocortical insufficiency Hypopituitarism Liver disease Ethanol ingestion Reactive hypoglycemia Glycogen storage disease
pH	Respiratory alkalosis Metabolic alkalosis	Respiratory acidosis Metabolic acidosis
PCO_2	Acute Respiratory Acidosis: • Depression of respiratory center • Suppressed neuromuscular system • Pulmonary disorders • Inadequate mechanical ventilation Chronic respiratory acidosis • Decreased alveolar ventilation • Hypoventilation Compensation in metabolic alkalosis	Respiratory alkalosis: • Increased stimulation of respiratory center • Hypermetabolic states • Mechanical hyperventilation Compensation in metabolic acidosis
PO_2	Breathing oxygen-enriched air	Carbon-monoxide exposure Pulmonary disorders Myocardial infarction Congestive heart failure
HCO_3	Primary metabolic alkalosis Compensation in respiratory acidosis	Primary metabolic acidosis Compensation in respiratory alkalosis
HEMATOCRIT	Dehydration Burns Impaired ventilation Renal disorders	Hemolytic anemias Iron deficiency Marrow depression Blood loss

C. **SPECIMEN ~~COLLECTION~~:**

1. Specimen Type:

Sample Type	Collection Device	Minimum Fill Volume	Preparation
Arterial blood	Syringe	200 microliters for 1.0 mL syringe	Expel air from the syringe and cap it immediately after obtaining

Venous blood		800 microliters for 3.0 mL syringe 1.5 mL for 5.0 ml syringe	the sample.
Capillary blood	Capillary tube	175 microliters balanced heparin tubes (Minimum is 100 microliters)	Fill the tube completely and cap it securely.

a. For whole blood samples, use syringe or capillary tube. For whole blood venous specimens submitted to the laboratory, use lithium heparin. If staff are analyzing samples for ionized calcium lithium heparin can be used.
b. Other anticoagulants, such as benzalkonium heparin, EDTA, citrate, oxalate, and fluoride significantly affect blood pH, sodium, potassium, chloride, and ionized calcium results.
c. Antimicrobial compounds such as silver sulfadiazine and chlorhexidine, which are found in some central venous catheters, significantly affect sodium results and may affect subsequent sample analyses. Do not collect venous samples for electrolytes analysis from a central venous catheter that contains silver sulfadiazine or chlorhexidine.
d. Staff can introduce samples into the ~~Rapidpoint 500~~**RAPIDPoint ® 500** system using the sample collection devices listed in the previous table.

2. Specimen Handling:
   a. Position any labels toward the back of the syringe barrel near the plunger so the label does not block the syringe from entering the system and cause it to fall off.
   b. Cap the sample device immediately after collection to avoid room air contamination.
   c. Analyze the sample as soon as possible to minimize oxygen consumption.
   d. Before analysis, roll the syringe or capillary tube between palms and gently invert it several times to mix the sample thoroughly. Blood cells settle during storage, and if the sample is not well mixed before analysis, the Hematocrit results obtained can be falsely decreased or increased. Mix all samples using a consistent technique. Ensure there are no air bubbles in the syringe after mixing.
   e. Dispose of used sample devices in a biohazard contamination bag.
3. Known Interfering Substances:
   a. Always select the mixed venous sample button to analyze mixed venous samples. Samples collected from some pulmonary artery catheters can contain the benzalkonium ion that interferes with analysis and affects results.

Analyte	Interfering Substance	Concentration Tested	Level of Interference
Ionized Calcium	Salicylic Acid	50 mg/dL 30 mg/dL	.098 mM (6%) .046 mM (3%)
Sodium	Dobutamine Benzalkonium Heparin Heparin Leo	5 mg/dL n/a 800-850 U/mL	6 mmol/L >50 mM -12.6 mM
Chloride	Salicylic Acid	50 mg/dL 20 mg/dL	9.5 mmol/L 1.8 mmol/L
Hematocrit	Dextran Leukocytes Protein Protein	3 g/dL 60,000 WBC cu/mm 12% 4%	5% 10% 4.9% -1.3%
Potassium	Benzalkonium Heparin		>0.15 mM

D. REAGENTS/ SUPPLIES:

1. **RAPIDPoint® 405/500 Systems Measurement Cartridge**
2. **RAPIDPoint® 405/500 Systems Wash/Waste Cartridge**
3. **RAPIDSystems™ AutomaticQC Cartridge**
4. **Syringe/ Capillary Tube**

E. CALIBRATION:

5. The system performs calibrations automatically at prescribed intervals and with each sample if necessary.
6. The system automatically calibrates the sensors as follows:
   a. One-point calibrations are scheduled to occur regularly at 30-minute intervals between calibrations.
   b. Every fourth scheduled calibration is a two-point calibration.
7. No operator action is required for calibration. If necessary, the system can defer a calibration to analyze a sample. In this case the message informing staff that the system is busy contains a STAT button that lets staff interrupt the calibration. However, if the maximum time between automatic calibrations has elapsed, the system must complete the calibration before allowing sample analysis.
8. During calibration, if the system detects a problem for a parameter, the system repeats the calibration for as many as two times. The Additional Cal Required message appears on the printed report and in the events log. If the calibrations are not successful, the system turns the parameter off. Staff can continue to obtain results for the other parameters. However, staff must wait for the parameter to pass the next calibration to obtain results for the parameter the system turned off.
9. The system performs additional calibrations during sample analysis for the first four hours after staff installs a new measurement cartridge. These calibrations ensure that the cartridge is ready for sample analysis. When these additional calibrations are required, sample results do not update during analysis, analysis time is prolonged due to additional calibration.

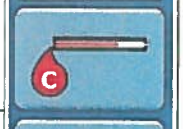
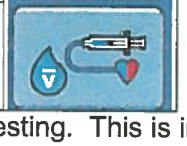
F. QUALITY CONTROL:

1. The AutomaticQC (AQC) analysis option performs quality control analysis at the scheduled time and for the scheduled level. The cartridge contains all the levels of QC material needed to monitor system performance without operator intervention.
10. During AQC analysis, the system compares the results to the ranges for each parameter and identifies any results that are out of range. Any parameters that fail QC are turned off. The system repeats QC analysis if the first attempt fails and turns on any failed parameters that pass. Any parameters that fail the second QC analysis are turned off.
11. The system allows staff to analyze a sample from the AQC cartridge in addition to the scheduled AQC. When staff analyze an AQC sample, the results can affect parameter status. The system turns failed parameters on that pass QC analysis for the failed level and turns parameters off that do not pass QC analysis.
12. The system automatically sends the QC results to the RapidComm data management system. This is to be reviewed periodically by approved Laboratory personnel.
13. Staff can interrupt AQC between levels if an urgent patient sample needs to be analyzed. Touch STAT on the AQC Results screen to delay analysis of the next level of QC material. When the system is ready, analyze the patient sample. The system analyzes any remaining levels of QC after staff finish.

~~D.~~G. PROCEDURE ~~FOR RESPIRATORY PERSONNEL~~:

~~1.~~**14.** Analyzing Patient Samples:
   a. Roll the syringe or the capillary tube between palms and gently invert it several times to mix the sample thoroughly.

b. Touch the button for the patient SAMPLE TYPE. A checkmark indicates the button is selected. (Default is arterial syringe).

i. Arterial (syringe)	
ii. Capillary (175 microliters Cap tube)	
iii. Venous (syringe)	
iv. Mixed venous blood (this will only do a pO2)	

c. Touch (select) the panel of choice to perform testing. This is important so that RapidComm selects the appropriate test panel in Cerner.

~~ABG Panel~~ ~~Neo ABG Panel~~	pH pCO_2 pO_2	✓ 1
~~ABG Coox~~ ~~Neo ABG Coox~~	pO_2 tHb	2
~~Cord Blood Gas~~	Ca^{++}	

d. Introduce the sample device into the sample port and touch the START button. The system aspirates the sample.
   i. Arterial or Venous: Place the syringe into the sample port.
   ii. Capillary: Insert the Capillary tube into the sample port until it clicks into place.

e. When prompted, remove the sample device from the sample port and touch the CONTINUE button.

f. When prompted, enter the following demographic information.
   i. Touch the Patient ID field and key in the patient's FIN number (performed in ICU, ED, NICU, PACU and OR) or the patient's accession number (performed in Lab).
   ii. Touch the Patient Name field and key in the patient Last Name.
   iii. Touch the Temperature field and key in the patient's temperature

g. Touch the ~~right~~ **CONTINUE button**~~arrow to continue~~.

h. View the results.

i. Touch **the** CONTINUE **button** when finished viewing results. The instrument will wash and prepare for the next sampling.

~~j. Open the RapidComm software to enter additional values (i.e. Draw Date & Time, Sample Site, Order Name, PCOM, FiO2/LPM, and Allen's Test).~~

~~k. If there are critical results, results will be displayed in red font and the Notified and Read Back field should be completed with the person receiving the results and credentials (i.e. Jane D, RN or Dr. Doe, MD); the Notified and Confirmed by field should be completed with the operator giving the results and credentials (i.e. J Doe, RCP); and the Notified Time field should be completed.~~

~~l. Once the results are reviewed, select OK for the results to record in Cerner.~~

~~2.~~**15.** Recalling Patient Results: Use this procedure to view and print results for patient samples that have already been analyzed.

a. Touch the Recall button. The recall button is the "File Folder" icon located in the upper right hand corner of the screen.
   i. Touch Patients: The list of patient samples appears.
   ii. Touch the desired sample to view.
   iii. Use the arrow keys to view additional samples. Select the sample.
   iv. Touch the Results button to view the results.
      1) Edit sample demographics by pressing the Edit button (for example, to change the temperature). If changed this will not be corrected in Cerner. The results have already been filed. To correct this in the computer, notify the laboratory.
      ~~1)~~**2)** To reprint results, touch the Print icon.
   v. Staff may search for a sample by patient by pressing the Search button.
      1) Enter in the Accession or FIN number and touch the ~~green arrow~~ **CONTINUE button**.

~~3.~~**16. Result Symbols**~~Reporting Results~~:

~~a. Calculations: The Rapidpoint 500 analyzer contains a microprocessor that performs all calculations required for reporting results.~~

~~b. Result Symbols:~~

↑	The result is above the patient range.
↓	The result is below the patient range.
-----↑	The result is above the reporting range. Send to Laboratory for analysis.
-----↓	The result is below the reporting range. Send to Laboratory for analysis.
-----?	The system has an atypical response when measuring this parameter and cannot report the result. Analyze the sample again. When this symbol appears for the HCT, it may indicate that the HCT result was not reported because Na failed Required QC or it was not performed
u	The HCT was not corrected for Na or K because the sensor is out of calibration, turned off, or beyond the reporting range. The system uses a default value of 140 mmol/L for Na or a value of 4 mmol/L for K to determine the HCT result.

~~c. Reference Intervals:~~

~~Analyte~~	~~Unit~~	~~Reference Range~~		~~Reportable Range~~
		~~Arterial~~	~~Venous~~	
~~Sodium~~	~~mEq/L~~	~~135 – 153~~		~~100 – 200~~
~~Potassium~~	~~mEq/L~~	~~3.5 – 5.3~~		~~0.5 – 15.0~~
~~Chloride~~	~~mEq/L~~	~~98 – 107~~		~~65 – 140~~
~~Glucose~~	~~mg/dL~~	~~70 – 110~~		~~20 – 750~~
~~Ion Calcium~~	~~mg/dL~~	~~4.5 – 4.9~~		~~0.80 – 20.0~~
~~pH~~		~~7.35 – 7.45~~		~~6.50 – 7.80~~
~~PCO_2~~	~~mm/Hg~~	~~35 – 45~~		~~10 – 150~~
~~PO_2~~	~~mm/Hg~~	~~>80~~		~~10 – 700~~
~~Hematocrit~~	~~%PCV~~	~~Males (adult) 42 – 52 Female (adult) 37 – 47~~		~~12-75~~
~~HCO_3~~	~~mEq/L~~	~~22 – 26~~		~~Calculated Results~~
~~TCO_2~~	~~mEq/L~~			
~~BE~~	~~mEq/L~~	~~(-2) – (+3)~~		
~~sO_2~~	~~%~~	~~94 -100~~	~~55-85 (sepsis >70)~~	

Analyte	Unit	Reference Range		Reportable Range
		Arterial	Venous	
Hb	g/dL	Males (adult) 14 – 18 Female (adult) 12 – 16		

d. Critical Results:

i. Critical results represent an emergency condition and must be reported immediately to the patient's attending physician or nurse.

ANALYTE (units)	CRITICAL VALUE	
	LOW < or =	HIGH > or =
ADULTS		
Sodium (mEq/L)	120	170
Potassium (mEql/L)	2.9	6.1
Glucose (mg/dL)	40	450
Ionized Calcium (mg/dL)	3.0	6.3
pH	7.30	7.52
PCO_2 (mmHg) when pH is >7.736	n/a	55
PO2 (mm/Hg)	55	n/a
Hematocrit (%PCV)	20.0	60.0
TCO2 (mEql/L)	10	45
NEONATES		
pH	7.28	7.50
PCO_2 (mmHg)	25	60
PO2 (mm/Hg)	50	100

E.H. PROCEDURE NOTES:

1. Status of Parameter Buttons:

✓pH	Parameters with checkmarks are selected (Touch to deselect test)
pH	This parameter is available but not selected.
	This parameter is not available because the sensor is out of calibration.
	This parameter is not available because the sensor is out of calibration and is unlikely to become available with further calibrations.
	YELLOW BUTTON: not available because the sensor has failed QC.
	PURPLE BUTTON: not available because Required QC was not performed.

2. Send specimen to the laboratory if staff has any questions concerning the operation or results of the RAPIDPoint ® 500.

1.3. Troubleshooting

a. The system messages can appear as follows:

i. **Messages can appear in a message box over the Analysis screen or over the Status screen.**
ii. **Messages can appear in the events log at the Status screen or in the events log that staff access from the Recall menu. For example, after staff replaces a depleted wash/waste cartridge, the message about the cartridge no longer appears at the Status screen but remains in the events log that staff access from the Recall menu.**
iii. **Refer to the Troubleshooting Section of the Siemens RAPIDPoint ® 500 Operator's Guide for the list of system diagnostic messages, its probable cause and corresponding corrective action to be performed. If further help is required, call POC Coordinator or the lab.**

4.17. Maintenance

a. Cleaning and Disinfecting the Screen: Clean the touch screen as needed to remove dust, dirt, or splatters from the screen and disinfect the screen surface.
   i. Materials:
      1) Hospital-approved disinfectant wipe
      2) Lint-free cloth
   ii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
   iii. Touch the Status button and then touch Clean Screen. The Clean screen appears for 20 seconds. This allows staff to wipe the screen without activating any buttons. While the Clean Screen is displayed, wipe the screen with the wet wipe and then thoroughly dry the screen with the lint-free cloth to remove chemicals that may damage the screen.
   iv. Touch the Continue button to return to the Analysis screen.

b. Cleaning and Disinfecting the Exterior Surfaces: Clean the exterior surfaces as needed to remove dust, dirt, and splatter from the surfaces, and disinfect the surfaces.
   i. Materials:
      1) Bleach disinfectant wipe
      2) Alcohol Pad
   ii. Caution: Do not wet the sample port or the sensor contacts for the measurement and Automatic QC cartridges. When cleaning surfaces do not spray cleaning solution or other fluids into or on the sample port or the area behind the cartridges. The sensor contacts, which are located behind the cartridges, may be damaged if they get wet. Sensors inside the cartridge may be damaged if cleaning solution enters the sample port.
   iii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
   iv. To disinfect the exterior surfaces: wipe, let remain wet for two minutes, then dry with a lint-free cloth.

c. Replacing the Printer Paper: Replace the printer paper when a pink stripe appears on the edge of the paper.
   i. Material:
      1) Printer paper
   ii. Grasp the latch on top of the touch screen and move the screen forward to expose the printer compartment.
   iii. Remove the old roll of paper:
      1) Open the printer compartment.
      2) If paper remains in the printer, tear off the paper below the printer. Caution: Do not pull the torn paper back through the printer. This can damage the printing mechanism.
      3) Turn the paper-advance knob clockwise to move the torn paper through the printer.
      4) Remove the old roll of paper.

5) Save the spindle for use with the new roll of paper.

iv. Install a new roll of paper:

1) Note: When advancing the paper, watch the paper move through the printer to ensure that it exits the printer correctly.
2) Get a new roll of paper and remove the outer wrapper.
3) Insert the spindle through the roll of paper and place the paper in the printer compartment. Ensure that the paper is tightly wound and the ends of the spindle fit into the grooves on the sides of the compartment.
4) Insert the paper from the bottom of the roll through the back of the printer. The system advances the paper automatically if the previous roll of paper was empty.
5) Turn the paper-advance knob clockwise to move 2-3 inches of paper through the top of the printer.
6) Note: When closing the printer compartment, ensure that the edge of the printer paper extends beyond the top of the printer.
7) Close the printer compartment.
8) Note: The first report printed after installing a new roll of paper does not have the Rapidpoint ~~405~~ **500** name printed at the top.
9) Adjust the position of the screen for viewing.

d. Replacing the Air Filter

i. Pull the air filter carrier out of the instrument (located on the bottom back right of the instrument).
ii. Remove the filter from the carrier.
iii. Install a new air filter in the carrier.
iv. Reinstall the air filter carrier in the instrument.

~~E. **CALIBRATION:**~~

~~1. The system performs calibrations automatically at prescribed intervals and with each sample if necessary.~~
~~2. The system automatically calibrates the sensors as follows:~~
~~a. One-point calibrations are scheduled to occur regularly at 30-minute intervals between calibrations.~~
~~b. Every fourth scheduled calibration is a two-point calibration.~~
~~3. No operator action is required for calibration. If necessary, the system can defer a calibration to analyze a sample. In this case the message informing staff that the system is busy contains a STAT button that lets staff interrupt the calibration. However, if the maximum time between automatic calibrations has elapsed, the system must complete the calibration before allowing sample analysis.~~
~~4. During calibration, if the system detects a problem for a parameter, the system repeats the calibration for as many as two times. The Additional Cal Required message appears on the printed report and in the events log. If the calibrations are not successful, the system turns the parameter off. Staff can continue to obtain results for the other parameters. However, staff must wait for the parameter to pass the next calibration to obtain results for the parameter the system turned off.~~
~~5. The system performs additional calibrations during sample analysis for the first four hours after staff install a new measurement cartridge. These calibrations ensure that the cartridge is ready for sample analysis. When these additional calibrations are required, sample results do not update during analysis, analysis time is prolonged due to additional calibration.~~

~~F. **QUALITY CONTROL:**~~

~~1. The AutomaticQC (AQC) analysis option performs quality control analysis at the scheduled time and for the scheduled level. The cartridge contains all the levels of QC material needed to monitor system performance without operator intervention.~~

2. During AQC analysis, the system compares the results to the ranges for each parameter and identifies any results that are out of range. Any parameters that fail QC are turned off. The system repeats QC analysis if the first attempt fails and turns on any failed parameters that pass. Any parameters that fail the second QC analysis are turned off.
3. The system allows staff to analyze a sample from the AQC cartridge in addition to the scheduled AQC. When staff analyze an AQC sample, the results can affect parameter status. The system turns failed parameters on that pass QC analysis for the failed level and turns parameters off that do not pass QC analysis.
4. The system automatically sends the QC results to the RapidComm data management system. This is to be reviewed periodically by approved Laboratory personnel.
5. Staff can interrupt AQC between levels if an urgent patient sample needs to be analyzed. Touch STAT on the AQC Results screen to delay analysis of the next level of QC material. When the system is ready, analyze the patient sample. The system analyzes any remaining levels of QC after staff finish.

G. PROCEDURE NOTES:

1. Status of Parameter Buttons:

✓pH	Parameters with checkmarks are selected (Touch to deselect test)
pH	This parameter is available but not selected.
	This parameter is not available because the sensor is out of calibration.
	This parameter is not available because the sensor is out of calibration and is unlikely to become available with further calibrations.
	YELLOW BUTTON: not available because the sensor has failed QC.
	PURPLE BUTTON: not available because Required QC was not performed.

2. Send specimen to the laboratory if staff have any questions concerning the operation or results of the Rapidpoint 500.
3. Proficiency Testing / Calibration Verification
   a. Before performing CAP proficiency testing or Siemens CVM samples user defined slopes and offsets must be removed.
   b. Following testing of these samples return the slopes and offsets to their calculated values.
   c. Calibration Verification must be performed every 6 months on each instrument.
      i. External QC
      ii. External QC must be run on each instrument every 30 days or when the measurement cartridge is replaced.
      iii. Run all three levels of Siemens RapidQC Complete.
      iv. Correlations
      v. Every 6 months perform a correlation between the Rapidpoint 500 instruments and the Laboratory Chemistry and Hematology instruments.
4. System Message: The system messages can appear as follows:
   a. Messages can appear in a message box over the Analysis screen or over the Status screen.

b. Messages can appear in the events log at the Status screen or in the events log that staff access from the Recall menu. For example, after staff replace a depleted wash/waste cartridge, the message about the cartridge no longer appears at the Status screen but remains in the events log that staff access from the Recall menu.

c. The following table lists the messages in alphabetical order. Refer to the instrument manual page 4-24 for a description of probable cause and corrective action. Notify LAB or POC Coordinator if staff have any questions with any of the following errors:

Message	Probable Cause and Corrective Action
AQC Cartridge Expired	Refer to Replacing the AutomaticQC Cartridge.
AQC Cartridge Not Valid	Unable to use the Cartridge.
AQC Connector is Open	Connector on the cartridge is open.
Additional Cal Required	A sensor experienced a calibration error.
Analysis is turned off by a remote computer.	Rapidlink data management system has turned off the system. Call LAB
Bubbles in the Sample.	The system cannot complete analysis due to bubbles or obstruction. Touch Continue to begin the sequence to clear the system. Replace the sample port when prompted. Analyze the sample again, ensuring that the sample has no bubbles.
Cal Overdue	Cal was delayed. The system must perform a calibration before staff can analyze samples.
Cal Not Done	The system performs an extended calibration.
D2 Excessive Drift: **D3 Slope Error:** **D4 Offset Error:**	The system turned the parameter identified in the message off because the sensor exceeded calibration limits. Subsequent calibrations may make the parameter available again.
D21 Processing Error	A system error occurred. When prompted, shut down the system. Call technical assistance if appears again.
D23 Reagent Error: 1-8 or 10-13	Inadequate flow of one or more reagents. System may prompt staff to replace the Wash/Waste or Measurement cartridges.
D23 Reagent Error: 9	Inadequate flow of one or more reagents. System may prompt staff to replace the sample port or Wash/Waste or Measurement cartridges.
D24 AQC Material Error	Inadequate flow of QC materials
D33 Valve Error: 1	A problem with the valve inside the measurement cartridge.
D33 Valve Error: 2	A problem with the valve inside the measurement cartridge.
D35 Electronics Error: 1-13	Error in the electronic components.
D35 Electronics Error: 14	A problem with the door.
D38 Temp Error: 1	Error in the temperature controls system because of a problem with the fan.
D38 Temp Error: 2-13	Error can occur if a component in the temperature control system has failed.

Message	Probable Cause and Corrective Action
D39 Obstruction	Obstruction or a sample not detected, and prompts staff to replace the sample port.
D40 Wash Not Detected	Fluidic components of a newly installed wash/waste cartridge have failed.
D41 No AQC Material Detected	Fluidic components of a newly installed wash/waste cartridge have failed.
D60 Communications Error	Error in communicating with the Rapidlink.
Door Error	Door not closed.
Insufficient Sample Volume.	The system cannot complete analysis. Touch Continue to begin the sequence to clear. Replace sample port when prompted.
M Cartridge Expired	Replace the Measurement and Wash/Waste Cartridges.
M Cartridge Not Valid	Expire cartridge was installed or not installed correctly as prompted.
No AQC Cartridge	Not installed
No M Cartridge	Not installed
No Paper in Printer	Out of paper.
No W Cartridge	Not installed
Out of Reporting Range:	The parameter shown is outside reporting range. Send specimen to lab.
QC Lot Not Defined	No Lot information is entered for QC
QC Material Expired	Define new lot of control
Question Result:	Atypical response when measuring parameter. Repeat.
Sensors Unavailable for QC	Out of calibration
System Error.	System will attempt to correct.
System Error. Power off and on	Electronic or processing error has occurred.
System require operator attention	- QC due — Cartridges are nearly expired or depleted — Failed QC
Temp Not Ready	Temperature of the sensor module is outside range.
Temp Out of Range	Does not report sample results
Temp Warning	New cartridge warming
The system detected an obstruction and cannot complete analysis.	Clot
The system did not detect a sample	No sample detected.
This password is expired.	Staff certification date has been exceeded and staff cannot access the system.
Uncorrected:	Hct not corrected because Na or K not calibrated.
Unrecoverable System Error.	Call for technical assistance.
Unsuccessful	Not connected to Rapidlink

~~Message~~	~~Probable Cause and Corrective Action~~
~~Connection.~~	
~~W Cartridge Expired~~	~~Replace Wash/Waste Cartridge~~

~~G.~~

~~H.~~G. **DOWNTIME:N/A**

H. **CALCULATIONS:**

1. The RAPIDPoint ® 500 analyzer contains a microprocessor that performs all calculations required for reporting results.

I. **AMR, CRR, REFERENCE RANGES, AND CRITICAL VALUES:**

1. Refer to Patient Care Services POC Quick Reference for AMR and Reference Ranges
2. Refer to Critical Tests and Critical Results Quick Reference Guide for Critical Results

J. **REPORTING OF RESULTS:**

1. Results coming from OR and PACU are automatically posted to Cerner thru RapidComm
2. Other location requires verification in RapidComm (Refer to RapidComm Instructions procedure)
   a. Open the RapidComm software to enter additional values (i.e. Draw Date & Time, Sample Site, Order Name, PCOM, FiO2/LPM, and Allen's Test).
   b. If there are critical results, results will be displayed in red font and the Notified and Read Back field should be completed with the person receiving the results and credentials (i.e. Jane D, RN or Dr. Doe, MD); the Notified and Confirmed by field should be completed with the operator giving the results and credentials (i.e. J Doe, RCP); and the Notified Time field should be completed.
   c. Once the results are reviewed, select OK for the results to record in Cerner.

K. **TECHNICAL NOTES:**

1. Refer to Appendix F: Principles of System Operation

L. **LIMITATIONS:**

1. Refer to Appendix E: Specifications section of the Siemens RAPIDPoint ® 500 Operator's Guide for the limitation of the system and each analytes.

M. **FORMS: N/A**

~~I.~~N. **RELATED DOCUMENTS:**

~~J.~~1. RapidComm Instructions Procedure
~~K.~~2. Patient Care Services POC Quick Reference
~~L.~~3. Critical Tests and Critical Results Quick Reference Guide
~~2.~~4. Siemens RAPIDPoint ® 500 Operator's Guide

~~F.~~O. **EXTERNAL LINKS: N/A**

~~G.~~P. **REFERENCE(S):**

1. ~~"105951 Rev J." *Siemens Rapidpoint 500 Series Operator's Manual*, 2011-2013. Print.~~ Siemens RAPIDPoint® 500 System Operator's Guide 10631336 Rev. C, 2019-10

Tri-City Medical Center	Patient Care Services

PROCEDURE: **SPECIMEN HANDLING FOR SURGICAL/PROCEDURAL AREAS**

Purpose: To outline the nursing responsibilities in handling of specimens:

1. ~~Pathology~~**Histology-Categories of Specimen Types**~~—page 3~~
    a. Permanent/Fixed~~—page 4~~
    b. Gross only~~—page 4~~
    c. Fresh~~—page 5~~
    d. Frozen Sections ~~—page 5~~
    e. Sterile Specimens~~—page 6~~
    f. Stones~~—page 7~~
    g. Lymph nodes~~—page 7~~
    h. Breast specimens~~—page 7~~
    i. Muscle biopsies~~—page 8~~
    j. Explants~~—page 8~~
    k. Forensic specimens~~—page 9~~
    l. Ciliary Motility~~page 9~~
    m. Molecular pathology studies/ special tumor studies~~—page 9~~
    n. Electron Microscopy~~—page 9~~
    o. Placentas, cord segments, foreskins~~—page 10~~
2. Microbiology~~—page 11~~
    a. Cultures: Aerobic, anaerobic, gram stain, fungus, viral~~—page 12~~
    b. Cultures: Acid Fast Bacilli (AFB)~~—page 12~~
3. Cytology~~—page 13~~

Supportive Data: **Without exception, ~~A~~all non-forensic** anatomical parts, tissue, and foreign objects removed in the operating room shall be sent to the Department of Pathology for examination per **California Code of Regulation** (CCR) Title XXII §70223 (g) ~~except those approved by the Pathology and Medical Executive committees and granted program flexibility~~ [CCR Title XXII §70129] by the California Department of Public Health, Licensing and Certification~~(See attachment A)~~. All tissues/materials not submitted for pathological exam shall be described in the operative report. The description shall include, but is not limited to,~~:~~ ~~N~~name/type~~,~~ **and** ~~L~~location of tissue/material removed. Any questions about handling of specimens shall be directed to the Histology department at extension 7914.

Equipment:
Plastic specimen bags (various sizes: small through extra large)
Red biohazard bags
Sterile specimen cup with lids
Culture tubes
Formalin
Formalin labels
Patient labels
~~Multispecimen labels (Appendix B)~~
Specimen log book
Laboratory requisition slips:
~~Tissue bone marrow~~**Histology, Cytology** (Appendix ~~C~~**BA**)
~~Breast tissue specimen log (Appendix D)~~
Microbiology (Appendix ~~E~~**CB**)
~~Cytology (Appendix F)~~
Rhino Probes
Equipment Furnished by Path Lab for Ciliary Motility
Chain of Custody Form

Department Review	Clinical Policies & Procedures Committee	Nurse Executive Committee	Operating Room Committee	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/94, 06/96, 08/96, 05/99; 05/00, 03/03; 12/05, 5/08, 12/11, **11/17, 03/18**	1/12, **05/18, 08/18, 03/20**	1/12, **09/18, 04/20**	**04/20**	**09/20**	n/a	7/12, **09/20**	**10/20**	8/16, **n/a**	8/12

A. **DEFINITIONS:**

1. **Allied Health Professional (AHP) - An individual credentialed/privileged to provide specified patient care, treatment and services.**

~~1.~~2. **Ciliary Motility:** The purpose of this study is to examine **in the Histology lab** directly ~~cilial~~ **ciliary** motility on living cells as well as prepare a specimen for ultrastructural examination (electron microscopy) of the cilia.

~~2.~~3. **Electron Microscopy (EM):** Allows investigators to visualize normal and abnormal cell anatomy under very high magnification, to observe the effects of experimental manipulation on cells and tissues, and examine fine structures. Tissue for EM must be hand-carried to Pathology immediately for immersion in special fixative. **Time is of the essence.**

~~3.~~4. **Exempt from submission:** Refers to specific tissue for which pathology examination after surgery is not required and/or for which no pathology report is generated, according to written institutional policy. However, there must be documentation in the operative record of all these items. **As of this date, the only exceptions are forensic evidence collected by law enforcement.**

~~4.~~5. **Explants:** Removed specimens, usually artificial or prosthetic, that have been implanted in a patient. Usually only require a gross exam.

~~5.~~6. **Fixation:** A general term used to describe the process of chemically preserving a sample of tissue to prevent deterioration.

~~6.~~7. **Fixative:** A chemical solution used to stabilize cellular components in preparation for histological examination. Proper fixation is essential for histology, but it destroys cells and acts in other ways that limits many research applications. 10% neutral buffered formalin is the most common routine fixative**, and it is the one we routinely use**. **The specimens must be immersed in formalin.**

~~7.~~8. **Forensic Specimen:** Bullets or other forensic objects removed from patients that may have future medical/legal consequences. It is therefore necessary that a "Chain ~~O~~of Custody" be maintained on these objects and that they be stored in a secure location. The objective of forensic evidence is to prove or exclude a physical connection between individuals and objects or places. Such evidence comprises a wide variety of substances or objects, the analysis of which requires specific, often specialized scientific skills.

~~8.~~9. **Fresh Specimen:** A specimen received in a container without fixative. Fresh tissue samples are processed **as soon as possible (**ASAP) to prevent tissue degeneration. **Time is of the essence.**

~~9.~~10. **Frozen Sections:** Denotes a step before tissue fixation whereby fresh tissue is rapidly frozen down to -20°C to make it ice-hard. This enables it to be very thinly cut on a special instrument (Cryostat) in Histology to prepare 5 micron-thick "sections." The sections are placed on glass slides and rapidly stained. The pathologist (in real time) interprets the results while the patient is still under anesthesia. Hence the term "frozen sections." **ALL TISSUES DESTINED FOR THIS USE MUST BE FRESH.**

~~10.~~11. **Frozen Specimen:** These are specimens that are or have been frozen for rapid microscopic exam during an intraoperative consultation. The pathologist selects a portion of the tissue sample for frozen section and immediate reading. Frozen section slides are cut on a cryostat instrument for rapid microscopic analysis. The remaining tissue, if any, is placed in a fixative and may be submitted for permanent sections at the discretion of the pathologist.

~~11.~~12. **Gross Only Examination:** Specimens examined in Pathology that are not examined microscopically ~~. The number and types of specimens submitted for "gross examination only" are based on written institutional policy, and~~ will be decided in Pathology. Specimens for "gross only" are usually foreign bodies, hardware, or those specimens not practical to be made into "permanents."

~~12. **Licensed Independent Practitioner (LIP)** - An individual credentialed/privileged to provide specified patient care, treatment and services.~~

13. **Molecular Pathology Studies:** It is a scientific discipline that encompasses the development of molecular and genetic approaches to the diagnosis and classification of human diseases, the design and validation of predictive biomarkers for treatment response and disease progression, the susceptibility of individuals of different genetic constitution to develop disease states, and the environmental and lifestyle factors implicated in carcinogenesis.

14. **Organ Donor Policy:** Organ donation is the process of removing an organ or a part of an organ for the purpose of transplantation into another person.
15. **Permanent:** As used here, usually denotes tissue or specimens that are to be placed in a **fixative**, such as **formalin**, which denatures the proteins in the tissue in order to preserve it indefinitely. Fixed specimens are processed in the pathology lab and embedded in paraffin blocks from which microscopic slides are prepared. The slides and blocks can be stored indefinitely at room temperature, hence the term "permanent."
16. **Specimen:** Any product of a medical procedure such as soft tissues, bones, fluids, foreign bodies, and surgical appliances/hardware. The terms "sample," "specimen," and "tissue" are often used interchangeably, but are not completely synonymous.

B. **POLICY:**

1. Each specimen shall go to the lab in a separate container to avoid misidentification.
2. Each specimen shall be identified by a completed label and accompanied by an appropriate lab requisition slip **per Patient Care Services Policy: Specimen Labeling Procedure**.
   - **a.** Each specimen must be entered on the requisition by its appropriate **alphabetic** letter**, in ascending order, without skipping a letter**. ~~Include pre-operative/pre-procedure diagnosis and brief clinical history.~~
   - ~~a.~~**b. Verify patient identification (two identifiers) on the patient's armband, medical record, specimen container, and each page of accompanying specimen requisition(s).**
3. All surgical specimens, or lack thereof, are verified with the **physician/AHP**~~LIP~~ **when passing specimens off the sterile field and** prior to completion of **the** surgical procedure.
4. **Scrubbed personnel shall confirm approval to pass the specimen off the sterile field with the physician/AHP prior to passing the specimen to the circulating Registered Nurse (RN).**
5. ~~4.~~ All tissue shall be taken to the pathologist intact. Never cut a specimen once it is removed from the patient unless requested by the ~~LIP~~**physician/AHP**.
6. Any small specimen sent fresh to ~~Pathology~~ **Histology** must be placed on a saline-moistened Telfa pad (for example, brain biopsies, endometrial curetting, and needle biopsies).
   - **a. Never place specimens on a dry pad or gauze**, as this will compromise the tissue.
   - ~~5.~~**b. The use of open-mesh gauze is prohibited.**
7. Never place specimens for fresh examination or frozen sections in formalin.
8. ~~6.~~ **Large specimens (such as limb amputations) shall be placed in double red bags and appropriately labeled. Place the bagged specimen in a rigid container labeled "Biohazard" and send to Histology immediately.**
9. ~~7.~~ Instruments or counted sponges are not sent to ~~Pathology~~**Histology**.
10. All specimens and verification of specimens sent shall be recorded **in the Operative Record,** on ~~an~~**the physician/AHP's** operative note and ~~documented in the~~ **copies of all specimen requisitions are placed in the department** Specimen Log Book.
11. ~~8.~~ **Specimen records shall be maintained in the originating department for ninety (90) days, then shredded.**
12. ~~9.~~ Gloves and eye protection must be worn when handling specimens and when filling specimen bags with formalin.
13. ~~10.~~ Any specimen preserved in formalin must have a formalin label on the container.
14. ~~11.~~ Explanted instrumentation and/or stones may be returned to the patient through the ~~Pathology~~ **Histology** department, if requested **on the Histology requisition**. Instructions for handling of the returned items shall be printed on the lab requisition form**, including specific directions on how to return the specimen to the patient (e.g., return to the surgeon's office or return directly to patient on inpatient unit) and note handling instructions for recalled implants/devices**.
15. A ~~p~~pathologist is **always available in-house from 8:00AM to 5:00PM Monday-Friday, except for hospital-observed holidays**~~readily available Monday-Friday 0800-1700~~**. There is a pathologist on-call 24 hours a day, 7 days a week for hours outside of these.**
    - **a. Please allow at least 60 minutes for the presence of a pathologist under on-call circumstances.**
    - ~~12.~~**b. Under all circumstances requiring the on-call pathologist, please provide maximum**

advance notice, even several hours if possible.

~~a. Specimens requiring immediate pathological examination after hours and on weekends require notification of the on-call pathologist.~~

~~i.~~**c.** Call the lab to page the on-call pathologist.

~~ii. Allow as much advanced notice as possible to the on-call pathologist (at least 1 hour).~~

~~13.~~**16.** Notify ~~Pathology~~ **Histology** when there is an impending or possible Life Sharing organ donation case.

a. The on-call pathologist must be paged for after-hours pathological examinations.

C. **PROCEDURE:**

1. ~~PATHOLOGY~~**HISTOLOGY**

~~1.~~**a. Documentation:**

~~a. Documentation and specimen handling:~~

~~i. Verify patient identification labels (two identifiers) with patient chart and armband~~

~~ii. Affix patient identification labels to:~~

~~1) Top of multispecimen label (Appendix B)~~

~~2) Specimen container~~

~~3) Top right hand corner of each of the four pages of the tissue-bone marrow requisition form (Appendix C)~~

~~iii. Verify identity of the specimen with the LIP and document on the specimen container.~~

i. Complete the ~~tissue-bone marrow~~ **Histology, Cytology ~~r~~Requisition form, including:**

1) Indicate the specimen is for Histology (check mark in box)

~~iv.~~**2) Document clinical history and surgical procedure**~~.~~

~~1) Document the pre-operative/pre-procedure diagnosis and other pertinent information/history under "clinical history."~~

~~2) Document the procedure under "specimen source."~~

~~3) Check the appropriate box for "tissue, specimen," "bone marrow," or "other" in the upper left-hand corner.~~

~~4)~~**3)** Document the name of the specimen as verified by the ~~LIP~~ **physician/AHP**, sequentially labeling the first ~~pathology~~ **histology** specimen "A," the second "B," etc.

a) If the surgical procedure does not produce a specimen, write "No Specimen" on the requisition and send the requisition to ~~Pathology~~**Histologythe lab slip box**.

~~5)~~**4)** Document the date, circulating nurse's name and ~~LIP~~**physician/AHP**'s name at the bottom of the form.

~~v. Complete the multispecimen label~~

~~1) Write the date on the patient label and affix the label to the top of the multispecimen label~~

~~2) Document the OR# and LIP's name~~

~~3) Document the name and origin of the specimen, sequentially labeling the specimens in the same manner as the tissue-bone marrow requisition~~

~~4) If the number of specimens is greater than the number of lines on the first multispecimen label, prepare a second label as above. Sequential lettering will continue in order of the first and/or subsequent labels.~~

~~5) On the right side of the multispecimen label, check the appropriate box for permanent, fresh or frozen~~

~~vi. Document all specimens on the Operative Record and document verification of specimens with the LIP.~~

b. **SPECIMEN COLLECTION AND HANDLING**

i. **Permanent/Fixed**

~~1) Scrubbed personnel shall:~~

~~a) Verify with the LIP that the specimen is ready to pass off the sterile field.~~

~~b) Pass the specimen off the sterile field to the circulating nurse.~~

~~2)~~**1)** The circulating nurse shall:

a) Verify the following information with the **physician/AHP**~~LIP~~:

i) Specimen name

ii) Whether specimen is to be "permanent," or placed in formalin.

b) Select the appropriate sized plastic specimen bag **or formalin pre-filled container** to receive the specimen **and receive the specimen from the sterile field into the chosen container**.

~~c) When appropriate, permanent/fixed specimens may be placed directly into pre-filled, formalin containers with an affixed formalin hazardous warning label.~~

~~d) Place the specimen in the labeled plastic specimen bag.~~

~~e)~~**c)** ~~At the end of the case b~~**B**ring the specimen to the OR specimen room and add formalin to the specimen bag, **covering the entire specimen with formalin**.~~.~~

~~i) If possible, try to cover the specimen with formalin.~~

~~f)~~**d)** Place a formalin sticker on the specimen bag.

~~g)~~**e)** Place the labeled specimen bag in the specimen collection box.

~~h)~~**f)** Place the ~~tissue-bone marrow~~**Histology, Cytology** requisition in the lab slip box. **Mark "Permanent" on the requisition.**

~~i) Place the multispecimen label in the Specimen Log book, with the appropriate "permanent" box selected.~~

~~3)~~**2)** Hematomas may be sent fixed in formalin.

ii. Gross only

~~4)~~**1)** Follow the same procedure as for permanent specimens, including the words "GROSS ONLY" written on the ~~tissue-bone marrow~~ **Histology, Cytology** requisition.~~ and multispecimen label~~

~~ii.~~**iii. Fresh (Not sterile specimen)**

~~1) Scrubbed personnel shall:~~

~~a) Verify with the LIP that the specimen is ready to pass off the sterile field.~~

~~b) Pass the specimen off the sterile field to the circulating nurse.~~

~~2)~~**1)** The circulating nurse shall:

a) Verify with the **physician/AHP**~~LIP~~ that the specimen is to be examined fresh in the ~~Pathology~~ **Histology** Department.

i) Include any special directions for examination by the pathologist.

i) If the ~~LIP~~ **physician/AHP** would like results reported intraoperatively, write, "Please examine fresh and call results to (OR extension)" on the ~~tissue-bone marrow~~ **Histology, Cytology** requisition. **Mark "Fresh" on the requisition.**

(1) Always include a phone number and OR room number when results need to be called to the OR.

~~ii) If no immediate report is necessary, the circulator shall simply write, "Please examine fresh" on the tissue-bone marrow Histology, Cytology requisition.~~

b) Select the appropriate sized plastic specimen bag ~~to~~ **and** receive the specimen **from the sterile field**.

i) Oversized specimens (i.e., limb amputations) shall be placed in double red biohazardous bags, with the bags secured at the opening.

~~c) Place the specimen in the labeled plastic specimen bag.~~

~~d) Select "Fresh" on the multispecimen label.~~

~~e)~~**c)** Send the fresh specimen **and accompanying requisition** to **the** ~~Pathology~~ **Histology department** immediately.

~~i) The specimen, multispecimen label and tissue-bone marrow requisition shall be brought to the surgery front desk.~~

~~ii) The Assistant Nurse Manager or charge nurse shall call appropriate personnel to transport the specimen to Pathology.~~

~~f)~~**d)** DO NOT PLACE FRESH SPECIMENS IN FORMALIN.

~~3)~~**2)** ~~Pathology~~ **Histology department** personnel receiving the specimen shall:

a) Initial**, date and time** -the ~~multispecimen label~~ **Histology, Cytology requisition**

b) Return the ~~label~~ **OR copy of the requisition** to the transporting personnel

~~4)~~**3)** Transporting personnel shall return the ~~multispecimen label~~ **OR copy of the requisition** to the circulating nurse in the OR.

~~5)~~**4)** The ~~multispecimen label~~ **OR copy of the Histology, Cytology requisition** shall be placed in the Specimen Log book at the conclusion of the case.

~~iii.~~**iv. Frozen Sections**

~~1) Scrubbed personnel shall:~~

~~a) Verify with the LIP that the specimen is ready to pass off the sterile field~~

~~b) Pass the specimen off the sterile field to the circulating nurse.~~

~~2)~~**1)** The circulating nurse shall:

a) Verify with the ~~LIP~~ **physician/AHP** that frozen sections are required.

b) Select the appropriate sized plastic specimen bag ~~to receive the specimen~~ **and receive the specimen from the sterile field**. **Attention must be paid to whether the tissue is intended for culture <u>and</u> frozen section. In such a case, the container must also be <u>sterile</u>.**

~~c) Receive the specimen in the labeled plastic specimen bag.~~

~~d) If the sample is small, mount it on a saline moistened Telfa pad. It is any larger, mounting is not necessary, but place a saline-moistened 2x2 gauze inside the bag.~~

~~e)~~**c)** ~~Write~~ **Mark for** "Frozen Section~~s~~**" on the Histology, Cytology requisition and write**~~,~~ **"**Please call results to (OR extension and OR room number)"~~ on the tissue-bone marrow requisition~~. **It is important to write the OR phone number on the requisition.**

~~f) Select "Frozen Sections" on the multispecimen label.~~

~~g)~~**d)** Send the specimen to ~~Pathology~~ **the Histology department** immediately.

~~i) The specimen, multispecimen label and tissue-bone marrow requisition shall be brought to the surgery front desk.~~

~~ii) The Assistant Nurse Manager or charge nurse shall call appropriate personnel to transport the specimen to Pathology.~~

h) DO NOT PLACE SPECIMENS FOR FROZEN SECTIONS IN FORMALIN.

2) ~~Pathology personnel~~ **Histology department personnel receiving the specimen shall:**

a) Initial, date and time the Histology, Cytology requisition
b) Return the OR copy of the requisition to the transporting personnel
c) Refer to the procedure Laboratory Pathology / Histology / Policy and Procedure Manual / Frozen Section Preparation and Staining for details.

3) Transporting personnel shall return the OR copy of the requisition to the circulating nurse in the OR.

4) The OR copy of the Histology, Cytology requisition shall be placed in the Specimen Log book at the conclusion of the case.

~~3) receiving the specimen shall:~~
~~a) Initial the multispecimen label.~~
~~b) Return the label to the transporting personnel.~~
~~5) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~
~~6) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

~~7)~~**5)** Frozen sections obtained on weekends, holidays, and after 5:00 PM weekdays require as much notice as possible, with ~~thirty minutes~~**one hour** notification to the lab ~~minimally~~**at a minimum**.

a) The on-call pathologist needs as much prior notice as possible that frozen section evaluation will be requested.

6) The pathologist ~~usually~~ **preferably** delivers the results of the frozen section **directly** to the ~~LIP~~**physician/AHP**.

a) The pathologist needs to speak directly to the ~~LIP~~ **physician/AHP** to ~~i~~ensure accurate communication regarding the specimen results. **The loudspeaker/microphone system is not preferred, as there are too many echoes originating in the OR.**

b) ~~The circulating nurse shall hold the phone to the LIP's ear when the results are phoned~~**While it is preferable for the physician/AHP to receive the diagnosis directly from the pathologist, if the pathologist is unable to speak directly to the procedural physician/AHP,** ~~. Alternatively,~~ the nurse may relay the diagnosis VERBATIM to the ~~LIP~~ **physician/AHP** while the pathologist stays on the telephone **for confirmation, and to address any questions**.

~~c) It is preferable for the LIP to receive the diagnosis directly.~~

v. **Fresh and Sterile Specimens**

~~1) Scrubbed personnel shall:~~
~~a) Verify with the LIP that the specimen is ready to pass off the sterile field.~~
~~b) Pass the specimen off the sterile field to the circulating nurse.~~

~~2)~~**1)** The circulating nurse shall:

a) Verify with the ~~LIP~~ **physician/AHP** that the specimen is to be sent fresh and sterile.

b) Obtain a sterile specimen container with lid.

i) Place ~~the~~**a** specimen that is too large for a specimen cup in a sterile basin and cover with ~~a transparent Vi-drape~~**loban**.

ii) Note: **Zip-lock** ~~S~~specimen bags are not sterile.

c) Receive the specimen **from the sterile field** in**to** the labeled sterile specimen container.

d) ~~Select~~ **Mark** 'fresh" on the ~~multispecimen label~~**Histology, Cytology requisition** ~~and note the specimen is sterile~~.

e) Send the specimen to ~~Pathology~~ **the Histology department** immediately.

~~i) The specimen, multispecimen label and tissue-bone marrow requisition shall be brought to the surgery front desk.~~
~~ii) The Assistant Nurse Manager or charge nurse shall call appropriate personnel to transport the specimen to Pathology.~~

f) DO NOT PLACE FRESH, STERILE SPECIMENS IN FORMALIN

2) Histology department personnel receiving the specimen shall:
a) Initial, date and time the Histology, Cytology requisition.
b) Return the OR copy of the requisition to the transporting personnel.

3) Transporting personnel shall return the OR copy of the requisition to the circulating nurse in the OR.

4) The OR copy of the Histology, Cytology requisition shall be placed in the Specimen Log book at the conclusion of the case.

~~3) Pathology personnel receiving the specimen shall:~~
~~a) Initial the label.~~
~~b) Return the label the transporting personnel.~~
~~4) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~
~~5) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

~~6)~~**5) Note: Individual specimens requiring both culture and ~~pathology~~ histology examination are to be sent to the Histology Lab first.**
a) Mark "Split Specimen with Microbiology" on the requisition.
~~a)~~**b)** The transporting personnel shall notify the Histology Lab that the specimen also requires culture.
~~b)~~**c)** ~~Pathology~~ **Histology** will ~~send~~ **divide** the specimen ~~to~~ **for** Microbiology.
~~c)~~**d)** Both a ~~tissue-bone marrow~~**Histology, Cytology** requisition and Microbiology requisition must accompany the specimen.

v. **Stones**
1) Stones shall be sent dry to ~~Pathology~~ **Histology** in a **sterile** specimen cup.
a) Exception: Tissue specimens that contain stones should be placed in formalin (i.e., gallbladder with stones).

vi. **Lymph Nodes**
1) **All** ~~L~~lymph nodes **for lymphoma workup or frozen section** shall be sent fresh to ~~Pathology~~**Histology**~~; almost all will have to be sterile~~.
~~2) Lymph nodes shall also be sent sterile (1) at the discretion of the LIP, or (2) if the disease may be infectious.~~
~~a) Sentinel lymph nodes must be sent fresh, but do not need to be sterile.~~
~~3)~~**2)** Do not add normal saline to the specimen.
~~4)~~**3)** Hand--deliver to ~~Pathology~~ **the Histology department** promptly.

vii. **Breast Specimens**
1) Send all specimens intended ~~for frozen section, estrogen receptors, or both~~**for gross evaluation of margins** as ordered by the ~~LIP~~**physician/AHP**, immediately to ~~Pathology~~**the Histology department**.
2) Document on the ~~Pathology~~ **Histology, Cytology** requisition ~~if the patient has had estrogen therapy, or if metastasis is present~~**the patient's history**.
~~3) Check with the LIP~~ **physician/AHP** ~~if estrogen receptors are required on all breast tissue sent to the lab. If so, send specimen fresh and state on tissue-bone~~**Histology, Cytology** ~~marrow requisition form if patient:~~
~~a) Is post-menopausal~~

~~b) On estrogen replacement therapy~~
~~c) Has metastatic cancer~~

~~4)~~**3)** If sending fresh~~ or frozen sections~~, send the specimen to the lab immediately after excision. If specimen is for permanent, ~~place~~**immerse completely** in formalin as soon as possible, but no longer than one hour after excision (see definition of permanent). **The sooner the better.**

6) Complete **the "Time Excised" and "Formalin Time" (if applicable) on all specimens, including lymph nodes,** ~~a Breast Tissue Specimen Log form to accompany all specimens~~ excised from breast cases:

~~a) Include all breast specimens and lymph nodes.~~
~~b) Document the specimen name, time excised from the patient and time specimen placed in formalin (if applicable).~~
~~c) Check the box for "Mammography" or "Pathology", indicating where the specimen shall be delivered first.~~
~~d) The Breast Tissue Specimen Form shall accompany the specimen, the tissue-bone marrow requisition and multispecimen label to the appropriate department, Mammography or Pathology.~~

~~7) If the breast tissue specimen requires an X-ray:~~
~~a) The circulating nurse shall:~~
~~i) Notify Mammography personnel at x7985 of the impending specimen for X-ray.~~
~~• NOTE: After 5:30pm call main Radiology department at x7832 to notify of impending breast specimen. A Radiology tech will go to Mammography and follow the procedure for processing surgical breast tissue specimens.~~
~~ii) Make note on the tissue-bone marrow requisition that X-ray is required, including the OR extension for reporting results.~~
~~iii) Immediately send the specimen and appropriate paperwork to the surgery front desk for transport to Mammography.~~
~~b) The Assistant Nurse Manager/Charge nurse shall:~~
~~i) Send an OR Aide/transporter to Mammography with the specimen and appropriate paperwork.~~
~~c) The OR Aide/transporter shall:~~
~~i) Take the specimen and paperwork to Mammography.~~
~~ii) Have Mammography personnel initial the multispecimen label acknowledging receipt of the specimen.~~
~~iii) Return the multispecimen label to the circulating nurse in the OR.~~
~~d) Mammography personnel shall:~~
~~i) Initial the multispecimen label upon receipt of the specimen and appropriate paperwork.~~
~~ii) Perform X-rays as appropriate.~~
~~iii) Transport the specimen and paperwork to Pathology department.~~

viii. ~~-~~**Muscle Biopsies**

1) When such a case is scheduled, alert ~~Pathology~~ **Histology department as soon as possible** of the impending muscle biopsy (special arrangements must be made by the lab). **This means days in advance, if known.**~~Do not delay notifying Pathology.~~

2) Must be sent fresh, on sterile Telfa, lightly moistened with normal saline (see procedure for handling of fresh specimens, above).
   a) Send two separate biopsies.
   b) Do not send the tissue clamped.

3) Send the muscle biopsy specimen immediately.
   a) Must be received by the lab within five minutes of excision.
      i) These biopsies receive very specialized handling in the lab.

ix. **Explants**
1) **All** explanted objects/medical devices must be sent to ~~Pathology~~ **Histology** for examination, identification and documentation.
2) Explanted defective medical devices must be reported to the manufacturer.
   a) The circulating nurse shall immediately notify the Department Director~~ or Supervisor~~**/designee**, who will notify Risk Management and Biomed Department (if applicable).
   b) The Risk Manager is responsible for reporting the failed medical device, as appropriate, to Hospital Administration, the manufacturer, the Food and Drug Administration (FDA) and / or the California Department of Public Health (CDPH), as outlined in Administrative Policy #8610-201, "Equipment/Medical Device Reporting/Sequestering~~.~~".
   c) All portions of the device should be retained together, as well as the packaging, if available.
   d) The removed medical device should not be decontaminated or sterilized before it is transported from the surgical suite.
   e) Documentation shall include the reason for removal, if known.
   ~~f) Explanted Vascular Grafts must have a completed tracking form.~~
      ~~i) Complete the tracking form, found on the OR vascular cart.~~
      ~~ii) Place the completed form in the Surgery Material Coordinator's mailbox.~~
3) Explanted instrumentation and/or stones may be returned to the patient **through the ~~Pathology~~ Histology department**, if requested. **In these cases:**
   a) Write specific instructions for returning the explant or stone to the patient (i.e. Send to ~~LIP's~~ **physician/AHP's** office for return to patient) on the ~~tissue-bone marrow~~**Histology, Cytology** requisition.
4) Explanted objects do not need to be placed in formalin, but may be placed in formalin if there is tissue remaining on the explant.
   a) Double bag the explant if placing in formalin (to prevent puncturing of the bag and a formalin leak).

x. **Forensic Specimens**
1) Forensic specimens should be handled in a manner that preserves the condition of the evidence and verifies that the evidence has been in secure possession at all times.
   a) Complete a Chain-of-Custody slip, which accompanies the specimen to the ~~Pathology~~ **Histology** Department.
   ~~a)~~**b) It is preferred for the RN to bring the specimen to Histology department with the Chain-of-Custody slip. The pathologist will dictate the specimen and return it to law enforcement.**
   c) The least amount of people as possible should handle the specimen (i.e. Explanting ~~LIP~~**physician/AHP**, Circulating nurse, Lab personnel).
   ~~b)~~**d) The RN shall document in the OR Nursing Record where the specimen was sent/to whom the specimen was released.**

xi. **Ciliary Motility**
1) Schedule all Ciliary Motility studies with ~~Pathology~~ **Histology** ~~at least 24~~

~~hours in advance~~**when the case is booked by the surgery schedulers.** Call directly to Histology at **760-**940-7914.

2) Obtain the following materials from ~~Pathology~~ **Histology** 15-30 minutes prior to anticipated procedure (maintain supplies at room temperature):
   a) Test tube rack
   b) Two centrifuge tubes with caps
   c) One tube must contain pink RPMI media.
   d) One must contain 3% Glutaraldehyde in phosphate buffer.
3) Obtain at least two "Rhino ~~p~~**P**robes" from operating room supply. ~~(look like small plastic curettes).~~
4) Label each tube with the patient's identification per routine, and complete the ~~tissue-bone marrow~~**Histology, Cytology** requisition ~~and multispecimen label~~.
   a) Complete labeling and paperwork <u>prior</u> to obtaining the specimen to facilitate timely transport to the lab.
5) Once the ~~LIP~~ **physician/AHP** has obtained a specimen, place entire probe into tube and securely cap. Repeat for the second tube.
   a) Take care not to shake or agitate the probe or solution.
6) Histologist will wait for specimen and transport back to lab. **NOTE:** Time lapse between obtaining specimen and examination by pathologist **<u>MUST NOT</u>** exceed 15 minutes. **Time is of the essence.**
~~7) Pathology personnel receiving the specimen shall:~~
   ~~a) Initial the multispecimen label.~~
   ~~b) Return the label to the transporting personnel.~~
~~8) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~
~~9) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

xii. **Molecular Pathology Studies/Special Tumor Studies**
1) Must be pre-arranged by appointment with the company representative, the ~~LIP's~~ **physician/AHP's** office, the ~~Pathology~~ **Histology** department and OR personnel.
   a) Necessary supplies must be brought in for specimen handling.
   b) Specific directions for specimen handling shall be relayed from the ~~Pathology~~ **Histology** department to OR personnel.

xiii. **Electron Microscopy**
1) Must be pre-arranged between the ~~LIP's~~ **physician/AHP's** office, the ~~Pathology~~ **Histology** department and OR personnel.
2) Require STAT processing; may be performed during regular business hours only.
3) Specimen must be brought to ~~Pathology~~ **Histology department** fresh, within one minute of removal. ~~Speed~~**Time** is of the essence.

xiv. **Placentas~~, Cord Segments, Foreskins~~**
1) ~~All~~ **Most** placentas shall be sent to the lab for pathological analysis**(dependent on provider order or if the patient wishes to take the placenta home.**
   a) If the patient wishes to take the placenta home, refer to the Women and Newborn Services Policy: ~~put "do not process" on the Histology,Cytology requisition. See~~ Placenta Release to Patient/Family Except For Those Sent to Pathology ~~Women and Newborn Services policy~~.
      i) Note: Once the placenta has been released to the laboratory, it cannot under any circumstances be returned to the patient.
2) A completed ~~tissue-bone marrow~~**Histology, Cytology** requisition must

accompany each placenta.

~~b)~~**a) Note for Placentas delivered in main OR, follow step 7 a through g and bring to lab "Fresh" immediately after collection.**

~~2)~~**3)** The "clinical history" shall include documentation of the Estimated Date of Confinement (EDC), and approximate Gestational Age (GA) and where appropriate **write** "No Risk Factors Noted."

~~3)~~**4)** Additional documentation of "clinical history" shall include the following risk factors**, but is not an all-inclusive list of the risk factors**:

a) Twin placenta
b) Premature infant
c) Prolonged ruptured membranes
d) Maternal infection
  i) Isolated maternal fever ("documented" fever)
  ii) Suspected Triple I
  iii) Confirmed Triple I
  ~~d)~~ ~~(suspect chorioamnionitis,~~

~~i)~~**e) Group-beta streptococcus** (GBS) ~~⊕~~ **positive**~~, etc.)~~

~~e) Intrapartum temperature greater than 100.4°F (38°C)~~

f) Low birth weight or **intra-uterine growth restriction** (IUGR)
g) Congenital anomalies
h) Abruptio placenta
i) Post term infant
j) Fetal demise
k) Maternal medical problems
l) Maternal drug use
m) Multiple gestation
n) Placentas~~,~~ which appear abnormal (velamentous insertion of the cord, battledore, succenturiate, circumvallate, etc.)
o) 2 vessel umbilical cords
p) Abnormal blood gases
q) Meconium-stained placentas
r) Placenta previa

~~4)~~**5)** Include any additional lab test, information or orders as requested by physician**/AHP**.

~~5)~~**6)** Microbiology form (aerobic/anaerobic cultures)

~~6)~~**7)** Placental specimens shall be handled as follows:

a) Place placenta in one of the two large specimen containers (zip-lock bags).
b) Ensure that the bag closure (zip-lock) is securely intact to avoid seepage of specimen fluids.
c) Wash off all blood and contaminants on the outside of the specimen container/bag.
d) Label this first bag with patient sticker containing patient's name, medical record number, physician name and Aztec barcode.
e) Refer to the Patient Care Services Specimen Labeling and Patient Identification procedures.

~~f) A second RN will verify accuracy of information on label. Place Cerner ID number (initials) on label.~~

~~g)~~**f)** Place this large plastic specimen bag containing the placenta into the 2nd large specimen bag and secure the bag closure.

~~h)~~**g)** Place the double-bagged specimen into ~~the~~**a** white paper bag

~~7)~~**8)** Send specimen (labeled according to above instructions) to lab with the following completed requisition form:

a) ~~Tissue-bone marrow~~**Histology, Cytology** form (**all** placentas shall have this form completed).
b) **Note**: Specimens for cultures (aerobic/anaerobic) must be taken at the time of collection/post delivery and sent to the laboratory as soon as possible, separately from the placenta.

~~8)~~**9)** Place requisition form(s) inside white paper bag containing the labeled specimen bag ~~(applies to Labor and Delivery)~~.

~~9) Record the placenta in the L&D placenta log book (applies to Labor and Delivery).~~

10) Place the prepared specimen and requisition(s) (white paper bag) in the L&D specimen refrigerator – DO NOT FREEZE ~~(applies to Labor and Delivery)~~.

11) The Lab shall collect the placentas on a regular daily basis ~~(applies to Labor and Delivery)~~.

12) The lab courier shall speak with the L&D ~~ANM/~~charge nurse to ensure ~~that~~ all placentas have been properly labeled, requisitions completed, and to verify orders and/or answer questions associated with the specimens ~~(applies to Labor and Delivery)~~.

13) All specimens will be accessioned in the lab by lab personnel.

14) In the event of a holiday and/or after hours, the specimens shall remain in the L&D specimen refrigerator until the next business day.

15) The Lab shall hold the placentas for a minimum of 14 days from the date of collection, or as directed by pathologist or neonatology for pending transfers of NICU infants. The Lab shall be responsible for disposal of the placentas.

16) The placenta may be requested to accompany the neonate **when the decision is made by the neonatologist at the time of delivery** for transport to referral site, e.g., Rady's Children's Medical Center or UCSD-NICU (For further pathological and/or chromosomal studies). **If decision is made to transfer the infant day after delivery, the placenta will have been processed in Histology and will not be available to transfer with the patient.**

~~17) Umbilical cord segments and foreskins (following circumcision) will be disposed of as follows:~~

~~a) Place in small red biohazardous bag and place in biohazardous waste container~~
~~Environmental Services (EVS) collects and handles as biohazardous waste.~~

~~b) **If a mother requests a cord segment, the cord is to be sent to Histology along with the request noted on the Histology Requisition.**~~

~~18)~~**17)** Documentation:
a) Document all specimens collected
i) For the OR staff, intra-operatively on OR record, and in computer.
ii) Document all specimens in the Specimen Log Book in the Specimen Room.
b) Document Chain-of-Custody if appropriate.

~~19) ***Note for OR*:**~~
~~a) Follow step – 7 a through g~~
~~b) Bring to lab **"Fresh"** immediately after collection.~~

2. MICROBIOLOGY

a. Documentation and specimen labeling
~~i. Verify patient identification labels (two identifiers) with the patient chart and armband.~~

~~ii. Affix patient identification labels to:~~
~~1) Top of the multispecimen label.~~
~~2) The specimen container.~~
~~3) Top right-hand corner of the Microbiology requisition form (Appendix E).~~
~~iii. Verify the identity of the specimen with the LIP and document on the specimen container.~~
~~1) Specimens sent to Microbiology shall be labeled sequentially as Culture & Sensitivities (i.e. C&S#1, C&S#2, C&S#3, etc.).~~
~~iv. Complete the multispecimen label.~~
~~1) Write the date, the patient label and affix the label to the top of the multispecimen label.~~
~~2) Document the OR# and LIP's name.~~
~~3) Document the name of the specimen, sequentially labeling the specimens in the same manner as the microbiology requisition.~~
~~4) If the number of specimens is greater than the number of lines on the first multispecimen label, prepare a second label as above. Sequential lettering will continue in order on subsequent labels.~~
~~5) On the right side of the multispecimen label, check the appropriate box for Microbiology.~~

~~v.~~i. A completed Microbiology requisition form shall accompany all specimens for culture:
1) Indicate if the specimen needs a ~~Pathology~~ **Histology** examination
a) If the specimen needs both ~~Pathology~~ **Histology** and Microbiology attention, all specimens are to be **sent to Histology Lab first** with clear directions.
i) Both ~~a~~ Microbiology ~~requisition~~ and ~~tissue-bone marrow~~**Histology, Cytology** requisitions shall be completed and ~~sent with~~**accompany** the specimen.
2) Document the name of the person collecting the specimen under "Collected by."
3) Document the ordering physician under "Requested by."
4) Document the pre-operative/pre-procedure diagnosis under "Clinical Impression."
5) Document the name, date and time of last antibiotic under "Antimicrobi~~al~~**ic** therapy."
6) Document the date and time of specimen collection.
7) Place an "X" to indicate the site of culture under the "Specimen" section.
a) If none of the selections are applicable, write in the specimen source on a blank line.
8) Place an "X" next to the requested tests.

ii. Verify the identity of the specimen with the physician/AHP and document on the specimen container.
~~8)~~**1) Specimens sent to Microbiology shall be labeled sequentially as Culture & Sensitivities (i.e. C&S#1, C&S#2, C&S#3, etc.).**

~~9)~~**iii.** A separate Microbiology requisition is required for each specimen.

iv. Document all specimens **and specimen verification with the physician/AHP** on the Operative Record.~~ and document verification of specimens with the LIP.~~

v. Microbiology personnel receiving the specimen shall:
1) Initial, date and time the Microbiology requisition
2) Return the OR copy of the requisition to the transporting personnel

vi. Transporting personnel shall return the OR copy of the requisition to the circulating nurse in the OR.

~~vi.~~**vii. The OR copy of the Microbiology requisition shall be placed in the Specimen Log book at the conclusion of the case.**

b. **Specimen Collection and Handling**

i. **Cultures: Aerobic, Anaerobic, Gram Stain, and Fungi and Viral Cultures:**

1) ~~If a STAT gram stain is required write "STAT GRAM STAIN, call results to (OR Extension)" on Microbiology requisition form and send the specimen to the lab immediately~~**The circulating nurse shall:**

a) Verify the following information with the physician/AHP:

i) Specimen name (site).

ii) Cultures/tests to be ordered.

b) Receive the specimen from the scrub personnel and label the sterile specimen cup with a patient label and specimen name.

c) Place the labeled specimen container in a plastic bag for transport to Microbiology.

2) Send the culture to Microbiology accompanied by a completed Microbiology requisition form.

~~1)~~**3) If a STAT gram stain is required write "STAT GRAM STAIN, call results to (OR Extension)" on Microbiology requisition form and send the specimen and requisition to the lab immediately.**

~~3) Send the tissue to Microbiology accompanied by a completed multispecimen label and Microbiology requisition form.~~

~~4) Microbiology personnel receiving the specimen shall:~~

~~a) Initial the multispecimen label.~~

~~b) Return the label the transporting personnel.~~

~~5) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~

~~6) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

ii. **Culture: A.F.B.**

1) ~~ALL~~**All** AFB cultures must be sent in a sterile container.

a) Send as much tissue/liquid as possible.

b) Swabs are not acceptable.

~~2) Open sterile specimen cup with lid to sterile field.~~

~~3) Scrubbed personnel shall:~~

~~a) Verify with the LIP that the specimen is ready to pass off the sterile field~~

~~b) Place the specimen for culture in the sterile specimen cup with lid.~~

~~c) Pass the specimen off the sterile field to the circulating nurse~~

~~4) The circulating nurse shall:~~

~~a) Verify the following information with the LIP:~~

~~i) Specimen name (site).~~

~~ii) Cultures/tests to be ordered.~~

~~b) Receive the specimen from the scrub personnel.~~

~~c) Label the specimen cup with a patient label and specimen name.~~

~~d) Place the labeled specimen in a plastic bag for transport to Microbiology.~~

~~5) Send the culture to Microbiology accompanied by a completed multispecimen label and Microbiology requisition form.~~

~~6) Microbiology personnel receiving the specimen shall:~~

~~a) Initial the multispecimen label.~~

~~b) Return the label the transporting personnel.~~

~~7) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~

~~8) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

3. **CYTOLOGY**

~~a. Documentation and specimen handling~~

~~i. Verify patient identification labels (two identifiers) with the patient chart and armband.~~
~~ii. Affix patient identification labels to:~~
~~1) Top of the multispecimen label.~~
~~2) The specimen container.~~
~~3) Top right-hand corner of each of the four pages of the Cytology requisition form (Appendix F).~~
~~iii. Complete the multispecimen label.~~
~~1) Write the date on the patient label and affix to the top of the multispecimen label.~~
~~2) Document the OR# and LIP's name.~~
~~3) Document the name of the specimen, sequentially labeling the specimens in the same manner as the Cytology requisition.~~
~~4) If the number of specimens is greater than the number of lines on the first multispecimen label, prepare a second label as above. Sequential lettering will continue in order on subsequent labels.~~
~~5) On the right side of the multispecimen label, check the appropriate box for Cytology.~~

~~iv.~~**a.** A completed **Histology,** Cytology requisition form shall accompany all specimens for Cytology**, including**:

i. Indicate the specimen is for Cytology (check mark in box)
ii. Document clinical history and surgical procedure.
iii. Specify the method of collection for urine specimens (e.g., catheterized verses clean-catch).

~~1) Document the pre-operative/pre-procedure diagnosis and pertinent patient information/history under "Clinical History."~~
~~2) Document the procedure under "Specimen Source."~~
~~3)~~**iv.** Document the name of the specimen as verified by the **physician/AHP**~~LIP~~, sequentially labeling the first Cytology specimen "A," the second "B," etc.
~~a)~~**v.** Document Bronchoscopy specimens as ordered by the physician:
~~i)~~**1)** ~~Needle~~ **Bronchial** biopsy
~~ii)~~**2)** **Wang** ~~N~~needle biopsies/aspirate **slides**
~~iii)~~**3)** **Wang** ~~N~~needle biopsy rinse
~~iv) Bronchial biopsies~~
~~v)~~**4)** Bronchial ~~washings~~**brushings**
~~vi)~~**5)** Bronchial ~~brushings~~**washings**
vi. All slides must be labeled in pencil on the frosted end with two patient identifiers.
~~b)~~**vii.** Include a number next to the sequential letter for Bronchoscopy needle rinse or wash of brushing (i.e. Bronchial brushing=B-1, Wash of brushing=B-2).
~~c)~~**viii.** Document the **specific** specimen site **of origin** for all Bronchoscopy Cytology specimens (i.e. Bronchial biopsy-Right Lower Lobe).
~~4)~~**ix.** Document the date, circulating nurse's name and ~~LIP's~~ **physician/AHP's** name at the bottom of the form.
~~v.~~**x.** Document all specimens on the Operative Record**,** ~~and document~~**including** verification of specimens with the ~~LIP~~**physician/AHP**.

b. **Specimen Collection and Handling**
i. Open sterile specimen cup with lid or syringe to the sterile field.
ii. The ~~LIP~~ **physician/AHP** shall fill the sterile cup or syringe with fluid for Cytology.
iii. Scrubbed personnel shall **place the appropriate sterile cap on the cup or syringe.**~~:~~
~~1) Place appropriate sterile cap on cup or syringe.~~
~~2) Verify with the LIP that the specimen is ready to pass off the sterile field.~~
~~3) Pass the specimen off the sterile field to the circulating nurse.~~
iv. The circulating nurse shall:

1) Verify with the ~~LIP~~ **physician/AHP** that the specimen is to be sent to Cytology.
2) Receive the sterile specimen cup or syringe from the scrubbed personnel **and label the specimen container with patient label and specimen name.**~~.~~
~~3) Label the specimen container with patient label and specimen name.~~
~~4~~**3)** Send the specimen to Cytology immediately.
~~a) The specimen, multispecimen label and Cytology requisition shall be brought to the surgery front desk.~~
~~b) The Assistant Nurse Manager or charge nurse shall call appropriate personnel to transport the specimen to Cytology.~~
4) Cytology personnel receiving the specimen shall:
a) Initial, date and time the Histology, Cytology requisition
b) Return the OR copy of the requisition to the transporting personnel
5) Transporting personnel shall return the OR copy of the requisition to the circulating nurse in the OR.
~~4~~**6) The OR copy of the Histology, Cytology requisition shall be placed in the Specimen Log book at the conclusion of the case.**
~~c) Initial the multispecimen label.~~
~~d) Return the label to the transporting personnel.~~
~~5) Transporting personnel shall return the multispecimen label to the circulating nurse in the OR.~~
~~6) The multispecimen label shall be placed in the Specimen Log book at the conclusion of the case.~~

D. **FORMS**
1. **Histology, Cytology Requisition Form - Sample**
2. **Microbiology Requisition Form – Sample**
~~Tissue-Bone Marrow Requisition Form - Sample~~
~~D.~~**3. Chain of Custody Form – Sample**

E. **RELATED DOCUMENTS:**
1. **Laboratory Pathology / Histology / Policy and Procedure Manual / Frozen Section Preparation and Staining**

F. **REFERENCES**
1. ~~"Recommended Practices for the Care and Handling of Specimens in the Perioperative Environment". AORN Perioperative Standards and Recommended Practices, 2011 Edition~~**AORN Guidelines for Perioperative Practice, 2017 Edition.**
2. College of American Pathologists (2008). Quality Management in the Anatomic Pathology Laboratory: Promoting Patient Safety through Risk Management and Continuous Improvement. Northfield Ill.
3. **Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of Perioperative Registered Nurses.**
4. **The American College of Obstetrics and Gynecologists Committee Opinion. Intra partum Management of Intraamniotic Infection. Number 712. August 2017.**
~~3.~~**5. Obstet Gynecol. Evaluation and Management of Women and Newborns With a Maternal Diagnosis of Chorioamnionitis. 2016 March; 127(3): 426-436. Doi:10.1097/ACOG.0000000000001246.**

SAMPLE

Chain-of-Custody

1. Explanting Physician:		
Specimen:		
Date:	Time:	
2. Received by:		Dept:
Position:	Date:	Time:
3. Received by:		Dept:
Position:	Date:	Time:
4. Received by:		Dept:
Position:	Date:	Time:
5. Received by:		Dept:
Position:	Date:	Time:
6. Received by:		Dept:
Position:	Date:	Time:
7. Received by:		Dept:
Position:	Date:	Time:
8. Attach Business Card or Copy of Photo I.D. of Officer Receiving Specimen:		
Date:		Time:

Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056, (619) 724-8411

Chain-of-Custody

Addressograph

~~ATTACHMENT A~~

~~TISSUES EXEMPTED FROM PATHOLOGIC EXAM~~

1. ~~Foreign bodies, that for legal reasons, are given to law enforcement representatives at the time of surgery~~
~~Cataracts~~
2. ~~**Explanted ureteral stents????**~~

DELETE

APPENDIX B

MULTISPECIMEN LABEL

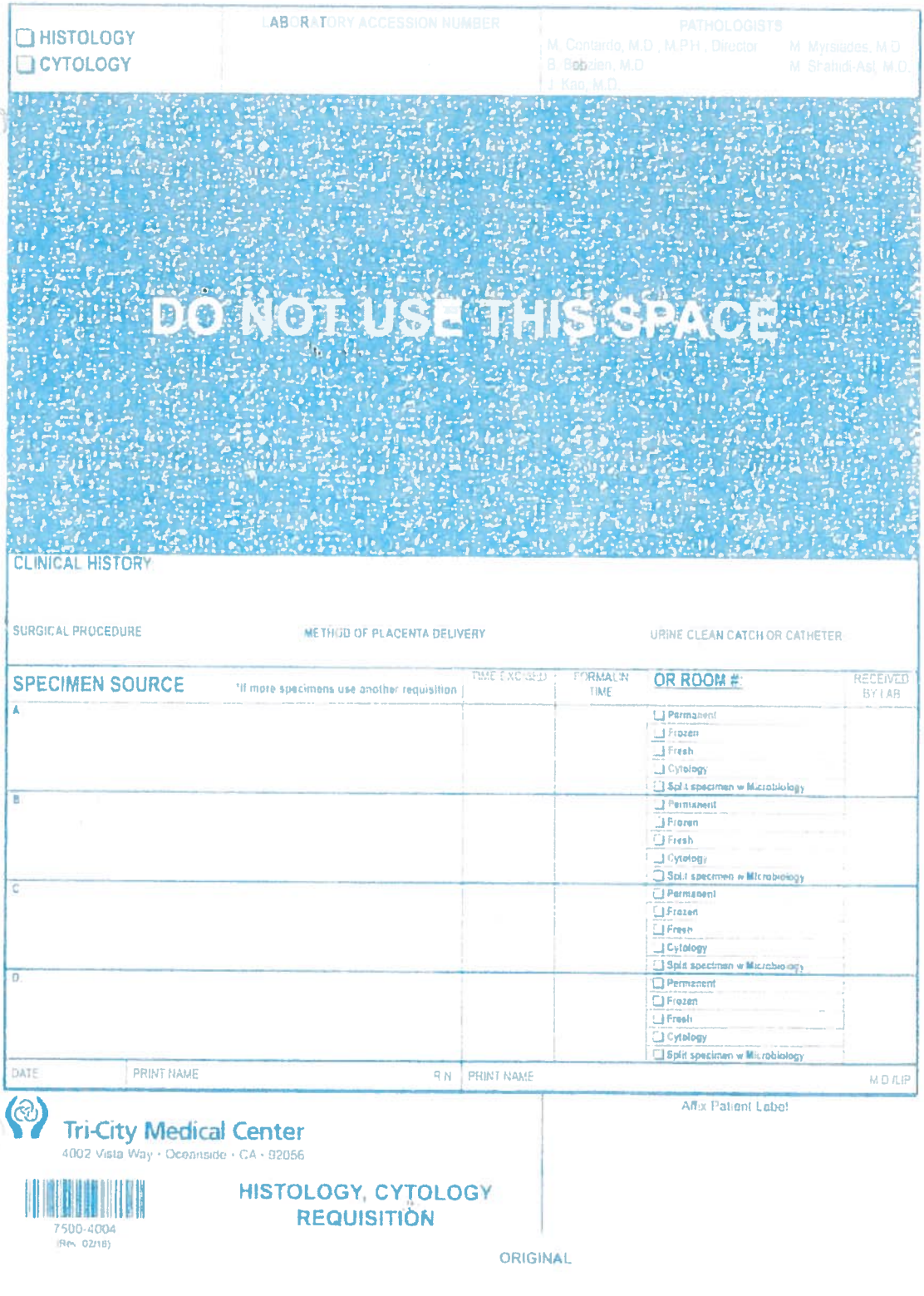
Affix Patient Label

OR # _____ SURGEON: _____

SPECIMEN	☐ Permanent
	☐ Fresh
	☐ Frozen
	☐ Micro
Received by Lab	☐ Cytology

SPECIMEN	☐ Permanent
	☐ Fresh
	☐ Frozen
	☐ Micro
Received by Lab	☐ Cytology

~~Appendix C~~
~~TISSUE-BONE MARROW~~ HISTOLOGY, CYTOLOGY REQUISITION FORM - Sample



☐ HISTOLOGY
☐ CYTOLOGY

LABORATORY ACCESSION NUMBER

PATHOLOGISTS
M. Contardo, M.D., M.P.H., Director M. Myrsiades, M.D.
B. Bobzien, M.D. M. Shahidi-Asl, M.D.
J. Kao, M.D.

DO NOT USE THIS SPACE

CLINICAL HISTORY

SURGICAL PROCEDURE | METHOD OF PLACENTA DELIVERY | URINE CLEAN CATCH OR CATHETER

SPECIMEN SOURCE (If more specimens use another requisition)	TIME EXCISED	FORMALIN TIME	OR ROOM #	RECEIVED BY LAB
A			☐ Permanent ☐ Frozen ☐ Fresh ☐ Cytology ☐ Split specimen w Microbiology	
B			☐ Permanent ☐ Frozen ☐ Fresh ☐ Cytology ☐ Split specimen w Microbiology	
C			☐ Permanent ☐ Frozen ☐ Fresh ☐ Cytology ☐ Split specimen w Microbiology	
D			☐ Permanent ☐ Frozen ☐ Fresh ☐ Cytology ☐ Split specimen w Microbiology	

DATE | PRINT NAME | R.N. | PRINT NAME | M.D./LIP

Affix Patient Label

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

7500-4004
(Rev. 02/18)

HISTOLOGY, CYTOLOGY REQUISITION

ORIGINAL

DELETE

APPENDIX C

TISSUE-BONE MARROW REQUISITION FORM

PRESS HARD WITH BALL-POINT PEN - YOU ARE MAKING 4 COPIES

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

TISSUE, BONE MARROW

☐ TISSUE, SPECIMEN
☐ BONE MARROW
☐
OTHER

LABORATORY ACCESSION NUMBER

CLINICAL HISTORY

SPECIMEN SOURCE — SPECIMENS AS IDENTIFIED BY SURGEON

A	F
B	G
C	H
D	I
E	J

DATE	SIGNED RN	DATE	SIGNED M.D.

7500-4004
(Rev 3/11)

TISSUE, BONE MARROW
ORIGINAL

PATHOLOGISTS:
M. Contardo, M.D., M.P.H. Director
B. Bobzien, M.D.
J. Kao, M.D.
M. Mysiadis, M.D.
M. Shahidi-Asl, M.D.

DELETE

APPENDIX D

BREAST TISSUE SPECIMEN LOG

Tri-City Medical Center

☐ Pathology
☐ Mammography

PATIENT LABEL

BREAST TISSUE SPECIMEN LOG

Specimen Name	Tissue Excised		In Formalin Must be in formalin within 1 hour of excision	
	Date	Time	Date	Time

Record tissue excision and formalin times for ALL specimens associated with breast cases. Send this form to Pathology with the specimens. If specimen requires X-ray, notify Mammography at x5572.

Microbiology Requisition Form - Sample

M. Contardo, M.D., M.P.H., Medical Director

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
(760)940-7906 **MICROBIOLOGY** (760)940-7907

CLINICAL MICROBIOLOGIST
L.L. Tiosejo, Ph. D, D(ABMM)
(760) 940-7908

SPECIAL INSTRUCTIONS/ SUPPLEMENTAL SPECIMEN INFORMATION:	REQUESTED BY: , M.D.	Patient Information
DOES THIS SPECIMEN NEED A PATHOLOGY EXAM? ☐ YES ☐ NO IF YES, SEND TISSUE REQUISITION ALSO	CLINICAL IMPRESSION:	
	ANTIMICROBIC THERAPY:	
COLLECTED BY:	DATE:	TIME: AM PM

X	SPECIMEN	X	SPECIMEN	X	TEST REQUESTED	FOR LABORATORY USE ONLY
	ABDOMEN		RECTAL SWAB		AFB CULTURE/CONCENTRATED SMEAR	
	ABSCESS		SINUS		AFB DIRECT SMEAR	
	Site		SKIN		ANAEROBE CULTURE	
	AMNIOTIC FLUID		SPUTUM		CMV CULTURE	
	APPENDIX		STERILITY CULTURES		CRYPTOSPORIDIUM/ISOSPORA DETECTION	
	BARTLETT BRUSH		Pharmacy		FUNGUS CULTURE	
	Site		Lab Deionized Water		GC SCREEN	
	BIOPSY		Other		GENITAL CULTURE	
	Site		STOOL		GRAM STAIN	
	BLOOD		TISSUE		HERPES SIMPLEX CULTURE	
	Arterial		Site		INDIA INK PREP	
	Groshong		Tracheal/Transtracheal Aspirate		KOH PREP: Bronch Wash & Skin Scrapings for Fungus	
	Transfusion Reaction		URINE		RAPID SEROLOGICAL TESTS	
	Venous		Catheter		Cryptococcal Antigen (Serum or CSF)	
	BODY FLUID		Clean Voided		Group B Streptococcus (Serum, CSF)	
	Bile		Cystoscopic		Haemophilus influenzae (Serum, CSF)	
	Breast Milk		Ileal Loop		Helicobacter pylori antibody (Serum)	
	Joint Fluid		Kidney		Influenza A/B (Nasal Swab/Nasal Wash)	
	Pericardial Fluid		Nephrostomy		Mycoplasma pneumoniae (IgM)(Serum)	
	Peritoneal Fluid		Suprapubic		Neisseria meningitidis (Serum, CSF)	
	Pleural Fluid		Wound		Rotavirus (Stool)	
	Shunt Fluid		Site		RSV (Nasal Wash)	
	BONE				Strep A Screen Rapid - Throat	
	BONE MARROW				Streptococcus pneumoniae (Serum, CSF)	
	BRONCHIAL WASH				LEGIONELLA CULTURE	
	CATHETER TIP				LEGIONELLA URINARY ANTIGEN	
	Broviac				MALARIA SMEAR	
	Cordis				OCCULT BLOOD	
	Groshong				OVA AND PARASITES	
	Hickman				PARASITE IDENTIFICATION	
	Intracath				PINWORM PREP	
	Infus-A-Port				RESPIRATORY CULTURE	
	Med-I-Port				ROUTINE CULTURE	
	Multilumen				SKIN TESTING	
	Port-A-Cath				PPD	
	Quinton				STOOL CULTURE	
	Reef				STOOL FOR LEUKOCYTES (WBC'S)	
	Swan-Ganz				STREP SCREEN CULTURE	
	Uldall				THROAT CULTURE	
	Other				VIRAL CULTURE	
	CEREBROSPINAL FLUID				WET MOUNT:	
	CHEST TUBE DRAINAGE				Vaginal for Trichomonas/Yeast only	
	CLOTEST (Gastric Biopsy)				Wound Culture	
	DECUBITUS				OTHER	
	DRAINAGE					
	Site				PCR TESTING:	
	EAR				MRSA Screen (Nares only)	
	Left Right				Clostridium difficil toxin (Fresh stools only)	
	EYE				Influenza Antigens A/B/H1N1	
	O.D. (Right)				Chlamydia trachomatis/Neisseria gonorrhoeae (Voided Urine only)	
	O.S. (Left)					
	GALLBLADDER					
	GASTRIC ASPIRATE					
	GENITAL TRACT					
	Cervix					
	Penile					
	Urethra					
	Vagina					
	LESION					
	Site					
	NASOPHARYNX					
	NOSE					
	PUS					
	Origin					

7500-1001
(Rev 02/16)

RECEIVED BY LAB
Name: _____
Date/Time: _____
Specimens: _____

DELETE

APPENDIX E

MICROBIOLOGY REQUISITION FORM

M. Contardo, M.D., M.P.H., Medical Director

Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056
(760) 940-7906 **MICROBIOLOGY** (760) 940-7907

CLINICAL MICROBIOLOGIST
L.L. Tiosejo, Ph. D, D(ABMM)
(760) 940-7908

SPECIAL INSTRUCTIONS/ SUPPLEMENTAL SPECIMEN INFORMATION: DOES THIS SPECIMEN NEED A PATHOLOGY EXAM? ☐ YES ☐ NO IF YES, SEND TISSUE REQUISITION ALSO	REQUESTED BY: , M.D. CLINICAL IMPRESSION: ANTIMICROBIC THERAPY:	Patient Information
COLLECTED BY:	DATE: / TIME: AM PM	

X	SPECIMEN	X	SPECIMEN	X	TEST REQUESTED	FOR LABORATORY USE ONLY
	ABDOMEN		RECTAL SWAB		AFB CULTURE/CONCENTRATED SMEAR	
	ABSCESS		SINUS		AFB DIRECT SMEAR	
	Site		SKIN		ANAEROBE CULTURE	
	AMNIOTIC FLUID		SPUTUM		CHLAMYDIA CULTURE	
	APPENDIX		STERILITY CULTURES		CHLAMYDIA EIA	
	BARTLETT BRUSH		Filters: Engineering		CLOSTRIDIUM DIFFICILE TOXIN	
	Site		Pharmacy		CMV CULTURE	
	BIOPSY		Lab Deionized Water		CRYPTOSPORIDIUM/ISOSPORA DETECTION	
	Site		Other		DARK FIELD MICROSCOPY (SPIROCHETES)	
	BLOOD		STOOL		FECAL FAT STAIN	
	Arterial		TISSUE		FUNGUS CULTURE	
	Groshong		Site		GC SCREEN	
	Transfusion Reaction		Tracheal/Transtracheal Aspirate		GENITAL CULTURE	
	Venous		URINE		GRAM STAIN	
	BODY FLUID		Catheter		HERPES SIMPLEX CULTURE	
	Bile		Clean Voided		INDIA INK PREP	
	Breast Milk		Cystoscopic		KOH PREP Bronch Wash & Skin Scrapings for Fungus	
	Joint Fluid		Ileal Loop		RAPID SEROLOGICAL TESTS	
	Pericardial Fluid		Kidney		Cryptococcal Antigen (Serum or CSF)	
	Peritoneal Fluid		Nephrostomy		Group B Streptococcus (Serum, Urine, CSF)	
	Pleural Fluid		Suprapubic		Haemophilus Influenzae (Serum, Urine, CSF)	
	Shunt Fluid		Wound		Helicobacter pylori antibody (Serum)	
	BONE		Site		Influenza A/B (Nasal Swab/Nasal Wash)	
	BONE MARROW				Lyme Disease (Serum)	
	BRONCHIAL WASH				Mycoplasma pneumoniae (IgM)(Serum)	
	CATHETER TIP				Neisseria meningitidis (Serum, Urine, CSF)	
	Broviac				Rotavirus (Stool)	
	Cordis				RSV (Nasal Wash)	
	Groshong				Strep A Screen Rapid - Throat	
	Hickman				Streptococcus pneumoniae (Serum, Urine, CSF)	
	Intracath				LEGIONELLA CULTURE	
	Infus-A-Port				LEGIONELLA URINARY ANTIGEN "STAT"	
	Med-I-Port				MALARIA SMEAR	
	Multifumen				OCCULT BLOOD	
	Port-A-Cath				OVA AND PARASITES	
	Quinton				PARASITE IDENTIFICATION	
	Raaf				PINWORM PREP	
	Swan-Ganz				RESPIRATORY CULTURE	
	Udall				ROUTINE CULTURE	
	Other				SKIN TESTING	
	CEREBROSPINAL FLUID				Candida	
	CHEST TUBE DRAINAGE				PPD	
	CLOTEST (Gastric Biopsy)				Trichophyton	
	DECUBITUS				STOOL CULTURE	
	DRAINAGE				STOOL FOR LEUKOCYTES (WBC'S)	
	Site				STREP SCREEN CULTURE	
	EAR				THROAT CULTURE	
	Left Right				VIRAL/CMV CULTURE	
	EYE				WET MOUNT:	
	O.D. (Right)				Vaginal for Trichomonas/Yeast only	
	O.S. (Left)				Wound Culture	
	GALLBLADDER				OTHER	
	GASTRIC ASPIRATE					

DELETE

APPENDIX F

CYTOLOGY REQUISITION FORM

CYTOLOGY

LABORATORY ACCESSION NUMBER

(INCLUDE PREVIOUS BIOPSY AND/OR CYTO)

SPECIMEN SOURCE	SPECIMEN AS IDENTIFIED BY PHYSICIAN
A	L
B	F
C	G
D	H
DATE	SIGNED

M.D.

Tri-City Medical Center

CYTOLOGY

ORIGINAL

PATHOLOGISTS: M. CONTARDO, M.D., M.P.H., DIRECTOR
B. BOBZIEN, M.D., J. KAO, M.D., G. WILCOX, M.D.

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**TARGETED TEMPERATURE MANAGEMENT AFTER CARDIAC ARREST**
Purpose:	To manage comatose patients after cardiac arrest using cooling methods to induce hypothermia in order to improve neurological outcomes.
Supportive Data:	In studies of cardiac arrest, induced hypothermia protocols have contributed to improved neurological outcomes. This procedure is done in the Emergency Department (ED) and Intensive Care Unit (ICU).
Equipment:	Temperature Management System Ice packs Core body temperature monitoring system (bladder, rectal, esophageal, or pulmonary artery) Refrigerated (4°C) normal saline

A. **POLICY:**

1. Patient Indications:
   a. ~~Adults a~~Age 14 years and older.
   b. Cardiac arrest followed by return of spontaneous circulation.
   c. Persistent coma after cardiac arrest as evidenced by no eye opening, no speech, no purposeful response to noxious stimuli (Glasgow Coma Scale 8 or lower).
   d. Those able to maintain a systolic blood pressure greater than 90mmHg, with or without vasopressor agents after return of spontaneous circulation.
2. Absolute Contraindications:
   a. Active bleeding
   b. Severe sepsis
3. Relative Contraindications:
   a. Pregnancy (women < 50 years old must have a negative pregnancy test prior to initiating the protocol)
   b. Major head trauma
   c. Other causes of coma, i.e. drug overdose, pre-existing coma~~)~~
   d. Recent major surgery within 14 days
   e. Greater than 6 hours from return of spontaneous circulation
   f. Preexisting **do not resuscitate** (DNR) status

B. **DEFINITIONS:**

1. Cardiac Arrest – When the heart stops pumping blood effectively due to a lethal arrhythmia such as ventricular fibrillation or asystole, or due to mechanical failure such as in pulseless electrical activity (PEA).
2. Hypothermia – Core body temperature less than 35°C3. Severe hypothermia – Core body temperature less than 30° C

C. **PROCEDURE:**

1. Assessment:
   a. Confirm that patient meets eligibility criteria for targeted temperature management.
   b. Obtain physician orders.
   c. Verify that patient will not be going for immediate cardiac catheterization. If immediate cardiac catheterization is planned, targeted temperature management may be started after catheterization is complete.
   d. Perform neurological assessment, including Glasgow Coma Scale, before initiating therapy and at the end of therapy.
   e. Assess pupil response every hour if paralytics are used.

Department Review	Clinical Policies & Procedures	Nursing Executive Committee	Critical Care Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/12, 08/16, **11/19**	10/12, 09/16, **12/19**	10/12, 09/16, **02/20**	10/16, **06/20**	n/a	01/13, 02/17, **09/20**	**10/20**	02/13, 03/17, **n/a**	02/13, 03/17

f. Assess and document vital signs, including core body temperature, every 15 minutes during therapy.
   i. Assess core body temperature using one of the following methods, listed in order of preference:
      1) Pulmonary artery catheter
      2) Esophageal catheter
      3) Bladder or rectal probe.

g. Draw labs frequently, as ordered, to monitor patient for electrolyte abnormalities, coagulopathy, and infection.

2. Patient/Family Education:
   a. Explain the purpose of targeted temperature management and goals of treatment to family.
   b. Assure family that appropriate comfort measures will be taken (i.e. sedation and analgesia).
   c. Provide hypothermia teaching handout.
3. Initiation of hypothermia using the temperature management system:
   a. Artic Sun (topical cooling device)
      i. Artic Sun Instructions for Use
   b. Zoll Thermogard Intravascular System (intravascular device)
      i. Zoll Thermogard XP Instructions for Use
   c. Gaymar Cooling Blanket (topical device)
      i. Gaymar Cooling Blanket Instructions for Use
4. Communication:
   a. Notify the physician of any changes in patient condition, complications of treatment or if unable to reach target temperature within specified time frame.
5. Documentation:
   a. Time of initiation of hypothermia shall be documented in the medical record.
   b. Patient assessments and communication with the physician shall be documented in the medical record.

D. **RELATED DOCUMENTS:**
1. Artic Sun Instructions for Use
2. Zoll Thermogard XP Instructions for Use
3. Gaymar Cooling Blanket Instructions for Use

E. **REFERENCES:**
1. Geocadin, R.G., Koenig, M.A., Stevens, R.D., Peberdy, M.A. (2007). Intensive Care for Brain Injury after Cardiac Arrest: Therapeutic Hypothermia and Related Neuroprotective Strategies. Crit Care Clin; 22: 619-636.
2. Bernard, S. (2006). Therapeutic Hypothermia after Cardiac Arrest. Neurol Clin.; 24:61-71.
3. J.P. Nolan, et.al. (2003). Therapeutic hypothermia after Cardiac Arrest: An Advisory Statement by the Advanced Life Support Task Force of the International Liaison Committee on Resuscitation. Circulation. 108: 118-121.
4. Palmer, S. J. (2015). Nursing the Out-of-Hospital Cardiac Arrest Patient: Use of Targeted Temperature Management. British Journal of Cardiac Nursing, 10(7), 335-344 10p.
5. Mathiesen, C., McPherson, D., Ordway, C., & Smith, M. (2015). Caring for Patients Treated with Targeted Temperature Management. Critical Care Nurse, 35(5) e-1-e13 13p. doi;10.4037/ccn2015168.

Artic Sun Instructions for Use

1. Use the sizing chart to determine the appropriate size gel pads for the patient.
   a. Apply gel pads to the patient.
      i. Gel pads must be placed only on intact skin.
      ii. Gel pads may be placed over top of defibrillation pads.
   b. Connect the gel pads and temperature probe to the machine's console.
   c. Set the patient's target temperature to 33°C.
      i. Goal temperature is 32 - 34°C.
   d. Ensure the Arctic Sun is in "automatic mode" (can only be used with attached temperature probe.)
   e. Time to target should be at MAX.
   f. Document time of initiation of patient cooling in the electronic health record (EHR).
   g. Administer cold intravenous saline as necessary to facilitate patient cooling, per physician's order, if no evidence of pulmonary edema on chest x-ray.
   h. If core temperature is NOT decreasing by at least 1°C per hour, see the Arctic Sun troubleshooting guide.
   i. Notify the physician if unable to reach target temperature within 4 – 6 hours.
   j. Monitor the patient for shivering during cooling using the Bedside Shivering Assessment Scale (BSAS) and notify physician if shivering cannot be controlled with the medications ordered.
   k. Monitor the patient for hypokalemia during cooling.
   l. Avoid severe hypothermia.
   m. Assess and document skin condition every two hours during therapy.
2. Maintenance phase:
   a. Once the target temperature has been achieved, the patient will be maintained at 32 – 34 °C for 24-hours from the initiation of cooling.
   b. Monitor the Arctic Sun water temperature and flow rate hourly in the EHR. A decrease in water temperature may indicate increased resistance to cooling, such as with shivering or fever from an infectious source.
   c. If the water temperature remains less than 10°C for more than 8 hours, refer to the Arctic Sun troubleshooting guide.
3. Rewarming phase:
   a. Begin rewarming the patient 24-hours after the initiation of hypothermia.
   b. Set the patient's target temperature to 37°C.
   c. Set the rate of rewarming to 0.3°C per hour. (Please note that the default setting is to "warm – MAX." The rewarming rate must be changed in order to achieve slow, controlled rewarming over 12 hours.)
   d. Monitor the patient for hypotension related to rewarming, secondary to vasodilation.
   e. Potassium replacement should be conservative 8 hours prior to rewarming and during rewarming.
   f. Monitor for hyperkalemia during rewarming.
   g. After rewarming is complete the Arctic Sun pads may be left in place for a total of 5 days. Monitor for rebound hyperthermia and reinitiate cooling if necessary to maintain the patient's core body temperature less than 37.5°C.

Assisting with insertion of Zoll Quattro or Icy Catheter (note insertion procedure same as with central venous catheter insertion).

1. Assemble Supplies:
   a. Full body sterile drape
   b. Sterile gown for physician
   c. Sterile gloves for assistant and physician
   d. Mask with face shield for physician
   e. Full face shield for physician
   f. Caps for assistant and physician
   g. Gel hand hygiene solution
   h. Zoll Intravascular Temperature Management Catheter. **Each catheter insertion kit contains all the necessary line insertion equipment**
      ~~i. Each catheter insertion kits contain all the necessary line insertion equipment~~
      i. The "Quattro" heat exchange catheter is a 4 balloon femoral venous catheter preferred for post cardiac arrest patients who need cooling (orange and white package). This is a 9.3 French 45 cm catheter.
      ii. The "Icy" heat exchange catheter is a 3 balloon femoral venous catheter for post cardiac arrest patients who need cooling (blue and white package). This is a 9.3 French 38 cm catheter.
      ~~ii.~~ Catheter should be positioned so that the distal tip is in the inferior vena cava below its junction with the right atrium and parallel to the vessel wall. All balloons should reside within the vessel.
   i. Zoll Start Up Kit for the Thermogard
   j. 500 ml. IV bag of normal saline. Note: takes about 250 ml of normal saline to prime the Thermogard.
   k. Temperature probe connector for "T1" temperature from Foley catheter ; & secondary temperature monitoring source with temperature probe
2. Ensure physician/designated healthcare provider (HCP) has performed chlorhexidine skin antisepsis
3. Provide maximal barrier precautions for the inserting and assisting personnel (i.e., cap, mask, sterile gown, sterile gloves, and full body sterile drape)
4. Ensure "time out" is performed per Patient Care Standards (PCS) Universal Protocol procedure.
5. Ensure Central Line Insertion Procedure Checklist is completed in Cerner.
6. Confirmation of Line Placement:
   a. After insertion of the line by the physician, confirm placement with KUB or CXR but do not delay initiation of cooling while waiting for this to be done.
   b. Ensure line confirmation is documented in Cerner.
7. After femoral insertion keep patient's HOB at a 30 degree angle or less).
8. For ongoing maintenance and care of femoral catheter, refer to Central Venous Access Devices, Adults.
9. Machine set-up and connection to the patient
   a. The Zoll Thermogard consists of three major components: a recirculating chiller, a sterile fluid roller pump, and a temperature control system.
   b. The Thermogard is connected to a ZOLL catheter (a temperature-controlled central line catheter) by two small-bore plastic tubes (orange luers).
   c. Steps for Machine Set Up:
      i. Check the level of the coolant in the coolant well, add more sterile or distilled water if necessary to ensure fluid is filled to just below the indicated "Max" coolant line (note: clinical engineering will add to the coolant chamber propylene glycol as part of routine machine maintenance). Place a "do not discard" sticker on the round plastic coolant cap and be sure to return it to the top of the coolant chamber.

ii. Plug in the power cord and turn the power switch on. The machine will go through a self-test.
iii. Make the following selections on the system set-up display screens:
1) When asked if it is new patient, select "no" ~~for the TCMC Thermogard Trial~~. This will allow all data to be stored.
2) Bath Pre-Set: Choose Precool and Enter
3) Set Target Temperature: Turn the knob and select 33.0 C degrees for Hypothermia post-cardiac arrest with ROSC patients and then push "Enter".
4) For Normothermia patients select 36.~~5~~0 C degrees as target temperature.
5) Set low temperature alarm at 32.5 when using hypothermia.
6) Max Power, Control Rate or Fever: Turn the knob to select MAX Power and Enter
iv. Install the start-up kit tubing set.
1) Insert the heat exchange coil into the coolant well.
2) Insert the air trap into the air trap holder.
3) Open lid of roller pump. The large section of tubing goes into the roller pump.
4) Manually rotate the pump to facilitate loading of tubing (see quick reference guide attached to machine).
v. Load the pump tubing into the pump, following the tubing circuit diagram printed on the inside of the machine's top cover. The side of tubing with flange fits into the slot on the right side of the roller pump house.
vi. Firmly close the top cover of the pump.
vii. Hang 500 ml of sterile normal saline on the hook.
viii. Using aseptic technique, connect the tubing to the 500ml normal saline using the spike connector. Ensure that spike is all the way to the hub but be very careful that you do not puncture the bag as the spike is exceptionally long.
ix. Lift out the air trap from its holder and turn it upside down. Press and continuously hold the PRIME switch down until the air trap and tubing are completely flushed with saline (approx. 2 minutes).
x. Turn the filled air trap right side up and place it in the holder.
xi. Slip the insulating jacket over the saline container. Note: When you use this insulating jacket you will not be able to view the amount of fluid in the saline bag. Therefore, when using the insulating bag be sure to regularly check the fluid level in the saline bag. Normally there should be about 250 ml. in the 500 ml bag. If the saline bag level is decreasing in volume assess it for a leak.
xii. Route the tubing out of the machine through notches in the front of the console and through the channel at the rear of the console.
xiii. Close the top cover making sure the tubing is not kinked.

d. Connection to The Patient
i. Position the Thermogard near the patient's bed and lock the casters.
ii. Place the primary and secondary patient temperature probes in the patient.
1) Plug the cable from the primary temperature probe into T1.
2) Note: T2 will not display on the Thermogard.
iii. The supply and return connectors of the tubing are connected to each other. Use aseptic technique to disconnect the two catheters.
iv. Connect the male tubing connector to the female connector on the patient's ZOLL catheter.
v. Connect the female tubing connector to the male connector on the patient's ZOLL catheter (orange-to-orange connection).
vi. Position the tubing so that it is not kinked, obstructed, or cannot be dislodged by the patient's movement.
vii. Press the STANDBY/RUN button to place the Thermogard in the Run mode.
viii. RN will note time that rewarming is set to occur (24 hours from time of initiation of cooling).

~~vii.~~**ix.**

10. Disconnection / reconnection procedures:
    a. The Thermogard does not have a battery and will have to be disconnected if a patient needs to be transported.
    b. Temporary Disconnection From The Patient:
        i. Press the STANDBY/RUN button to place the Thermogard in standby mode. Do not turn the machine off.
        ii. Disconnect the temperature probes from their cables. Leave the temperature probes in the patient.
        iii. Using aseptic technique, disconnect Start up Kit tubing from the ZOLL catheter. Do not cap the orange ports, simply connect the two ends of the catheter to each other. Do the same with the start up kit tubing to ensure the ends stay clean. ** The product used for the evaluation has ORANGE luers. This is the updated product that was released in April. The orange luers are custom luers, which provide an additional safety feature and will not be able to connect to a luer lock syringe or IV tubing, thus preventing the possibility of a misconnection.
    c. Reconnection After a Temporary Disconnection:
        i. Using aseptic technique, reconnect the Start up Kit tubing to the ZOLL catheter.
        ii. Reconnect the temperature probes to their cables.
        iii. Restart the Thermogard by pressing the STANDBY/RUN button.
    d. Thermogard Rewarming & Normothermia
        ~~iv.~~**i. Begin rewarming 24 hours after initiation of cooling.**
        ~~v.~~**ii.** This machine will not automatically switch from cooling to rewarming.
        ~~vi. RN will note time that rewarming is set to occur.~~
        ~~vii.~~**iii.** Place Thermogard in STANDBY mode.
        ~~viii.~~**iv.** Push TARGET TEMPERATURE button and use the dial to change setting to desired temperature 36.5 degree Centigrade and then push "enter".
        ~~ix.~~**v.** Push Rate Degree Per Hour Button and dial in Controlled Rate. Turn to desired rate of .25 degrees Centigrade per hour and Enter. It ~~will~~ **should** take about 12 hours to go from 33 degrees to 36.5 degrees.
        vi. Place Thermogard back in RUN mode.
        ~~x.~~**vii. Once patient is normothermic, the Zoll Thermogard may be used to maintain normothermia by maintaining set target temperature at 36.5 degrees Centigrade.**
11. Line maintenance
    a. Catheter stabilization & Protection of the Patient's Skin: Once catheter is verified to be properly positioned utilize standard Central Venous Catheter care for the site.
    b. Recommended length of time for line use:
        i. Quattro (four balloons) and ICY (three balloons) femoral lines **may be used** ~~are good~~ for up to 4 days
        ~~ii. The Cool-line inserted via internal jugular or subclavian is good for 7 days~~
        iii. Triple Lumen ports are not power-**injectable** -ports.
        iv. If continued temperature management is desired after **the 4-day** dwell time of catheter is up, ~~simply~~ **a physician may consider** ~~replace~~ catheter **replacement** with new catheter kit over the wire.
            1) Replace Start up Kit tubing at 7 days or when ~~changing out~~ **replacing the** femoral **catheter** ~~line~~.
12. Ending Treatment
    a. Press the STANDY/RUN button. The pump stops turning and the Standby screen appear.
    b. Using aseptic technique, disconnect both tubing connectors from the ZOLL catheter.
    c. Disconnect the primary and secondary patient temperature probes.
    d. Press the knob and, select END PROCEDURE, then choose "download data later" and press knob once to confirm. Or simply turn off system. Patient data will be saved for 21 days.
    e. Prior to catheter removal, uncap and leave uncapped the inflow and outflow lumen. This will allow residual saline within the circuit to be expressed. Use a 20 ml slip-tip syringe

from the start up kit to aspirate from the balloons to ensure all the saline is removed prior to the line being removed (optional with the Quattro catheter, as long as the orange luers are open to air).

f. The RN or physician can remove the line. It is normal to feel slight resistance as each balloon on the catheter passes out of the patient.

13. Troubleshooting & other key points:
   - ~~14.~~**a.** Refer to the Thermogard User's Manual attached to each machine.
   - ~~15.~~**b.** Use FICK cardiac output rather than thermodilution cardiac output on these patients.
   - ~~16.~~**c.** The catheters are MRI compatible.
   - ~~17.~~**d.** The catheters are NOT power injectable.
   - ~~18.~~**e.** Mannitol may run through the ZOLL catheter, however the machine must be put on STANDBY for two minutes and the lumen must be flushed after the Mannitol has infused. This is to ensure the medication has not crystallized
   - ~~19.~~**f.** Check the coolant level each time the machine is initially started. The coolant contains propylene glycol and distilled water. Engineering will replace the propylene glycol annually. The nurse will only need to add distilled water, if needed.

REFERENCES:

1. Zoll Thermogard Operator's Manual 2015

Gaymar Cooling Blanket Instructions for Use

1. Targeted temperature management may be performed without the use of the Arctic Sun or Zoll Thermogard temperature management systems only if all of the Arctic Sun and Zoll temperature management machines are unavailable.
   a. Apply ice packs to the groin, sides of chest, axillae, neck and limbs to initiate cooling.
   b. Cold IV saline may also be administered, as ordered, to facilitate rapid cooling.
   c. The Gaymar cooling blankets should be placed beneath and on top of the patient, with a sheet between the patient and the blanket to protect the skin.
   d. The water temperature in the Gaymar system is adjusted manually to achieve the desired rate of cooling.
   e. Ice packs can be removed during the maintenance phase.
   f. After 24-hours, the water temperature must again be manually readjusted to achieve slow, controlled rewarming at a rate no faster than 0.5°C per hour.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**~~URINE CHEMISTRY USING A~~ URINE DIPSTICK~~, MEASURING~~ ANALYSIS, MANUAL READ PROCEDURE**
Purpose:	To outline nursing responsibilities for testing urine using dipsticks.
Supportive Data:	A Registered Nurse (RN) may perform this procedure. Testing using a urine dipstick is under the direction, authority, jurisdiction and responsibility of the Laboratory Director. Urine dipstick testing is considered definitive for the purpose of care and diagnosis.
Equipment:	Timer Paper Towel

A. **POLICY:**

1. Urine dipsticks are inert plastic strips which have attached different reagent papers for measuring urine chemistries. The dipstick provides a rapid, simple method for measuring pH, leukocytes, nitrite, protein, glucose, ketones, urobilinogen, bilirubin, blood, and hemoglobin in urine specimens. Testing is considered definitive for the purposes of care and diagnosis

B. **PROCEDURE:**

1. Verify Quality Control (QC) has been completed within at least 24 hours.
   a. Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well prior to testing
   b. Complete QC and record in log.
2. Collect voided urine in a clean container. A first-morning specimen is preferred, but random collections are acceptable.
   a. Test the urine within two hours (test immediately if testing for bilirubin or urobilinogen). If unable to test within two hours, refrigerate the specimen immediately and bring to room temperature before testing.
   b. Label the sample if the test is not performed at the bedside and in the presence of the patient.
   c. Mix well before testing.
3. Immerse the test strip into the container of urine and remove immediately.
   a. Make sure the reagent pads are totally immersed.
4. Draw the edge of the strip along the rim of the container to remove excess urine.
5. Turn the test strip on its side and tap once on an absorbent paper towel to remove excess urine.
   a. This also prevents the possible mixing of reagent chemicals which can produce reading difficulties.
6. Wait the appropriate time (per manufacturer's recommendation) and read the test. Accurate timing is essential.
   a. Color changes that occur after 2 minutes are of no clinical value.
   b. Match the test strip to the color and record results.
      i. Be sure the strip is properly oriented to the color chart on the test strip container.
      ii. Color changes that occur only along the edges of the pads should be ignored. Careful removal of excess urine will eliminate this effect.
7. Storage:
   a. Store all unused strips in the original bottle.
   b. Store at room temperature.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Executive Committee	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03,4/04,11/06,7/09,08/11, 04/15, 06/18, **01/20, 06/20**	09/11, 05/15, 07/18, **03/20, 07/20**	10/11, 05/15, 07/18, **04/20, 08/20**	03/16, 08/18, **09/20**	n/a	11/11, 04/16, 08/18, **05/20, 09/20**	09/18, **10/20**	1/12, 05/16, n/a	01/12, 05/16, 09/18

c. Do not remove desiccant from bottle.
d. Do not store in direct sunlight.
e. Do not use strips after their expiration date.
f. Once opened, strips are good until the expiration date listed on the bottle or six months after the open date, whichever is sooner.

B. **REFERENCE RANGES:**

Test:	Glucose	Bilirubin	Ketones	Specific Gravity	Blood	pH	Protein	Urobilinogen	Nitrite	Leukocytes
Normal:	Neg	Neg	Neg	1.010--1.035	Neg	4.6-8.0	Neg	Neg	Neg	Neg

C. **LIMITATIONS:**

1. Protein: A visibly bloody urine may cause elevated results.
2. Blood: Capoten (captopril) may reduce sensitivity. Certain oxidizing contaminates, such as hypochlorite, may produce false positive results. Microbal peroxidase associated with urinary tract infection (UTI) may cause false positive reaction.
3. Leukocytes: Elevated glucose, (greater than or equal to [>] 3g/dL), may cause decreased test results. The presence of cephalexin, cephalothin, or high concentration of oxalic acid may cause decreased test results. Tetracycline may cause decreased reactivity and high levels of the drug may cause a false negative reaction. Positive results may occasionally be due to contamination of specimen by vaginal discharge.
4. Nitrite: Pink spots or pink edges should not be interpreted as a positive result. A negative result does not rule out significant bacteriuria. False negative results may occur with shortened bladder incubation of the urine, absence of dietary nitrate, or the presence of nonreductive pathological microbes.
5. Glucose: Ketone bodies reduce the sensitivity of the test; a moderately high ketone levels (40mg/dL) may cause false negatives for specimens containing a small amount of glucose (75-125mg/dL) but the combination of such ketone levels and low glucose levels is metabolically improbable in screening.
6. Ketones: False trace results may occur with highly pigmented urine specimens or those containing large amounts of levodopa metabolites. Compounds such as mesna that contain sulfhydryl groups may cause false positive or an atypical color reaction.
7. pH: Bacterial growth by certain organisms may cause a marked alkaline shift (pH >8), usually because of the urea conversion to ammonia.
8. Specific Gravity: Highly buffered alkaline urines may cause low readings, while the presence of moderate quantities of protein (100-750 mg/dL) may cause elevated readings.
9. Bilirubin: Atypical colors (colors that are unlike the negative or positive color blocks shown on the color chart) may indicate that bilirubin-derived bile pigments are present in the urine sample and may be masking the bilirubin reaction. These colors may indicate bile pigment abnormalities and the urine specimen should be tested further (send to lab).
10. Urobilogen: Atypical color reactions may be obtained in the presence of high concentration of p-amino benzoic acid. False negative results may be obtained if formalin is present. Strip reactivity increases with temperature.

D. **DOCUMENTATION:**

1. Document the results in electronic health record.
2. Document QC results on the **Point of Care Quality Control Log - Urine Dipstick Manual Read** ~~log sheet.~~

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

1. Point of Care Quality Control Log ~~L&D~~ - Urine Dipstick **Manual Read** ~~and Nitrazine~~

F. **REFERENCE(S):**

1. Siemens Healthcare Multistix **10 SG** Package Insert. TN30516A. 06/2010.

Point of Care Quality Control Log - Urine Dipstick Manual Read

Unit:	Lab Review:

Quality Control			
Name of QC:		Lot #:	
QC Level:		Expiration:	

Reagent Strips	
Lot#:	
Expiration:	

Date of Testing	GLUCOSE	BILIRUBIN	KETONES	SG	BLOOD	pH	PROTIEIN	UROBILIN-OGEN	NITRITE	LEUKOCTE ESTERASE	Pass/ Failed	Initial

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTICK ANALYSIS USING SIEMENS CLINITEK STATUS + CONNECT**
Purpose:	To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regarding the status of carbohydrate metabolism, kidney and liver function, acid-base balance, and urinary tract infection.
Supportive Data:	A Registered Nurse (RN) may perform this procedure. Testing is under the direction, authority, jurisdiction, and responsibility of the Laboratory Director.
~~Equipment:~~	~~Siemens Clinitek Status Analyzer (Analyzer together with base component)~~ ~~Siemens Multisix 10SG dipstick~~ ~~Paper towel to blot~~ ~~2 levels Quality Control (QC) (current manufacturer provided by lab)~~

A. **PRINCIPLE:**

1. The Clinitek Status analyzer is for in vitro diagnostic use in the semi-quantitative detection of bilirubin, blood (occult), glucose, ketone (acetoacetic acid), leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen in urine samples.
   a. The Clinitek Status+ Analyzer provides more regulatory control than the previous Clinitek Status model, including connectivity options and QC lockout functions.
2. ~~If the movement of the test table is irregular or slow, this may be due to:~~
   ~~a. Heavy build up of dried urine on the test table – clean the test table~~
   ~~b. Low battery power – replace the batteries or use the power supply.~~
3. ~~Substances that cause abnormal urine color may affect the readability of test pads on the reagent strips (see Substances/Conditions Affecting Test Results).~~

B. **SPECIMEN:**

1. First-morning void specimen is preferred. If not available, use a specimen that has incubated in the bladder for at least 4 hours. A random-void specimen is acceptable, but may not register positive nitrite results.
2. Collect in a clean dry container.
3. Label with patient identification.
4. Test within one hour of collection or refrigerate for up to 24 hours and bring to room temperature before testing. (Bilirubin and urobilinogen decrease with time).

C. **REAGENTS/ SUPPLIES:**

1. **Siemens Multistix® 10 SG Reagent strips for urinalysis**
   a. **Storage: 15 – 30°C (59 – 86°F)**
   b. **Keep away from sunlight**
2. **Quality Controls (2 levels)**
   ~~C.~~**a. Storage:**
      i. **Unopened bottle: 2 – 8°C stable until expiration**
      ii. **Opened bottle: 20 - 25°C stable for 30 days**

D. **QUALITY CONTROL:**

1. **Quality Control: Two levels of quality control (QC) must be tested under the following conditions:**
   a. **Daily before performing patient tests**
   b. **Opening a new vial of test strips**
   c. **Training of new users**

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5/13, 05/15, 06/18, **06/20**	6/13, 05/15, 07/18, **07/20**	6/13, 05/15, 07/18, **08/20**	03/16, 08/18	n/a	7/13, 04/16, 08/18, **09/20**	09/18, **10/20**	09/13, 05/16, n/a	09/13, 05/16, 09/18

2. QC Procedure:
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well.
   b. If QC needs to be performed, the "Strip Test" button will not be available, and the QC button will say "QC Test Due".
   c. Select the QC button.
   d. Select "QC Strip Test"
   e. Operator: Select "Enter New Operator Name". Enter operator 'name' by
      i. Scanning badge barcode or
      ii. Toggle to numeric and type numeric – Employee ID
   f. Control: Select "Enter Lot and Expiration Date".
      i. Scan the barcode for the QC lot number.
      ii. Adjust the year and month of the expiration date.
   g. Strip: Select "Enter new lot and expiration date".
      i. Scan the barcode assigned to the vial of strips in use.
      ii. Adjust the year and month of the expiration date.
   h. Prepare Test:
      i. Mix the QC Vial well. Press "Start". You have 8 seconds to complete the following steps:
         1) Wet each pad of the strip with control material.
         2) Tap the edge of the strip onto a paper towel to remove excess liquid.
         3) Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
         4) At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. The instrument will compare the results obtained with pre-programmed expected results and determine a PASS or FAIL.
         5) Dispose of the strip and wipe clean the test strip holder.
         6) Repeat any levels of Failed QC as necessary.
         7) Verify reagent strips and QC has been stored properly and are not expired.
         8) Re-mix sample well.
         9) Clean the test-table insert.
         10) Refer to additional troubleshooting steps at the end of this procedure.
         11) Contact the lab for support.
   i. QC results are automatically log into the middleware.

~~D. **PROCEDURE:**~~
~~1. Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.~~
   ~~a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well.~~
   ~~b. If QC needs to be performed, the "Strip Test" button will not be available, and the QC button will say "QC Test Due".~~
   ~~c. Select the QC button.~~
   ~~d. Select "QC Strip Test"~~
   ~~e. Operator: Select "Enter New Operator Name". Enter operator 'name' by~~
      ~~i. Scanning badge barcode~~
      ~~ii. Typing CERNER code~~

~~iii. Toggle to numeric and type numeric – Employee ID~~
~~f. Control: Select "Enter Lot and Expiration Date".~~
~~i. Scan the barcode for the QC lot number.~~
~~ii. Adjust the year and month of the expiration date.~~
~~iii. Strip: Select "Enter new lot and expiration date".~~
~~iv. Scan the barcode assigned to the vial of strips in use.~~
~~v. Adjust the year and month of the expiration date.~~
~~g. Prepare Test:~~
~~i. Mix the QC Vial well. Press "Start". You have 8 seconds to complete the following steps:~~
~~1) Wet each pad of the strip with control material.~~
~~2) Tap the edge of the strip onto a paper towel to remove excess liquid.~~
~~3) Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.~~
~~4) At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. The instrument will compare the results obtained with pre-programmed expected results and determine a PASS or FAIL.~~
~~5) Dispose of the strip and wipe clean the test strip holder.~~
~~6) Repeat any levels of Failed QC as necessary.~~
~~7) Verify strips and QC has been stored properly and are not expired.~~
~~8) Re-mix sample well.~~
~~9) Clean the test table insert.~~
~~10) Refer to additional troubleshooting steps at the end of this procedure.~~
~~11) Contact the lab for support.~~
~~h. Record results on the Waived Testing QC log.~~

E. **PROCEDURE FOR PATIENT TEST**:

1. Select "Strip Test"
2. Operator: Select "Enter New Operator Name". Enter operator 'name' by
   a. Scanning badge barcode **or**
   ~~b. Typing alpha-CERNER code~~
   ~~c.~~**b.** Toggle to numeric and type numeric- Employee ID
3. Patient Information: Select "Enter New Patient"
   a. Enter the Patient's Last Name
   b. Enter the Patient's ID
4. Strip: Select "Enter new lot and expiration date".
   a. If available, select "use last lot"~~.~~ OR~~r,~~
   b. Scan the barcode assigned to the vial of strips in use.
   c. Adjust the year and month of the expiration date.
5. Prepare Test:
   a. Mix the sample well. Press "Start". You have 8 seconds to complete the following steps:
   b. Fully immerse the dipstick into the urine. Tilt slightly to the side ensuring all strip pads are wet. Slowly pull the strip out, dragging the edge of the strip along the rim of the vial to catch excess liquid.
   c. Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
   d. At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read.
   e. The analyzer automatically performs a calibration each time a strip is read. Do not push or pull the test table or bump the instrument while it is calibrating.)
   f. While the strip is reading, select the color and clarity of the urine.

g. Dispose of the strip and wipe clean the test strip holder.

6. Recall Results:
   a. From the main Select screen, touch the Recall Results button.
   b. Select to review Patient or Quality Control tests.
   c. Test results are listed chronologically, with the most recent being at the top. Use the up and down arrows to scroll and highlight the result you would like to recall. Touch Select to view.
   d. You may print. Touch done when finished.

F. **REFERENCES RANGAND CRITICAL VALUES:**

1. Critical Values
   a. Glucose greater than or equal to 1000 mg/dL shall be reported to patient's licensed health care provider (RN or MD)

2. Reference Ranges
   a. Refer to Patient Care Services POC Quick Reference

G. **LIMITATIONS:**

1. Interfering substances may cause false positive or false negative results.
   a. Refer to **Urine Dipstick Analysis Using Siemens Clintek Status Procedure - Substances Conditions Affecting Test Results.**

~~1. related documentsat the end of the procedure.~~
~~2. To Report Results~~
~~a. Results reported by the meter:~~

~~Test~~	~~Abbreviation~~	~~Units~~	~~REFERENCE RANGES:~~	
			~~Normal~~	~~Abnormal~~
~~Glucose~~	~~GLU~~	~~mg/dL~~	~~Negative~~	~~100 500 250 ≥1000~~
~~Bilirubin~~	~~BIL~~		~~Negative~~	~~Small Moderate Large~~
~~Ketone~~	~~KET~~	~~mg/dL~~	~~Negative~~	~~Trace 80 15 ≥160 40~~
~~Specific Gravity~~	~~SG~~		~~≤ 1.005 1.020 1.010 1.025 1.015 1.030 ≥ 1.035~~	~~N/A~~
~~Blood~~	~~BLO~~		~~Negative~~	~~Trace Moderate Small Large~~
~~pH~~	~~pH~~		~~5.0 6.5 8.0 5.5 7.0 8.5 6.0 7.5 ≥9.0~~	~~N/A~~
~~Protein~~	~~PRO~~	~~mg/dL~~	~~Negative~~	~~Trace, 30, 100, ≥ 300~~
~~Urobilinogen~~	~~URO~~	~~E.U./dL~~	~~0.2 1.0~~	~~2.0 4.0 > 8.0~~
~~Nitrite~~	~~NIT~~		~~Negative~~	~~Positive~~
~~Leukocytes~~	~~LEU~~		~~Negative~~	~~Trace Moderate Small Large~~

~~b. Critical Values:~~

~~i. Glucose greater than or equal to 1000 mg/dL shall be reported to patient's licensed health care provider (RN or MD)~~

~~c. Detectable Range for Reagant Area and Sensitivity:~~

H. **METER MAINTENANCE AND CLEANING:**

1. The test table is to be kept clean if the analyzer is to operate properly.
2. Nursing shall be responsible for the daily cleaning of the test table insert and weekly cleaning of the meter.
   a. To clean the Test Table Insert:
      i. Remove the insert and thoroughly clean with a hospital approved disinfectant.
      ii. Rinse both sides under running water
      iii. Dry and replace insert
   b. To clean the Meter:
      i. Turn analyzer off
      ii. Wipe the outside with a damp (not wet) cloth and mild detergent
         1) May use a hospital approved disinfectant after wringing out excess liquid
         2) Avoid liquid from enter the printer compartment and under touch display
3. Lab shall perform other cleaning and maintenance to include cleaning of test table and white calibration bar monthly.
   a. To clean the Calibration Bar:
      i. Remove the insert from the test table.
      ii. Remove the test table by pulling it slowly out of the analyzer.
      iii. Drain the drip tray, if necessary.
      iv. Examine the white calibration bar on the test table for dirt or discoloration under good lighting. If it appears dirty or discolored, wet a cotton-tipped stick or lint free cloth with distilled water and gently wipe and clean the calibration bar.
      v. Do not scratch, touch or mark the Calibration bar.
      vi. Allow the calibration bar to air dry.
      vii. Insert the test table and table insert back.
4. **Troubleshooting**
   a. If the movement of the test table is irregular or slow, this may be due to:
      i. Heavy buildup of dried urine on the test table—clean the test table
      ii. Low battery power—replace the batteries or use the power supply.
   b. Refer to Siemens Clinitek Status®+Operators Guide for other troubleshooting procedures.
5. **Complete the Point of Care Quality Control Log – Urine Clinitek.**

I. **FORM(S):**

~~1.~~**1. Point of Care Quality Control Log – Urine Clinitek**

~~1. Point of Care Quality Control Log L&D Urine Dipstick and Nitrazine~~

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

1. **Urine Dipstick Analysis Using Siemens Clintek Status Procedure -** Substances/Conditions Affecting Test Results

~~1.~~**2. Siemens Clinitek Status®+Operators Guide**

K. **REFERENCE(S):**

1. Siemens Healthcare Multistix® **10SG Reagent Strips** ~~Product~~**Package** Insert~~.~~. ~~TN30516A Rev. 06/10~~**11306391 Rev. A 07-2017**

~~1. Siemens Clinitek Status Connect System Operator's Guide~~

2. ~~(-135955) Rev. B, 2011-06~~**Siemens Clinitek Status®+Operators Guide 10490853 Rev. C, 2011-12**

~~L. TECHNICAL ASSISTANCE:~~

~~1.~~**3.** ~~Siemens HealthCare Technical Care Center: 1-877-229-3711 Option 13; option 2~~

POINT OF CARE QUALITY CONTROL LOG - URINE CLINITEK

UNIT:	Instructions: 1. Indicate Lot #s. Verify Reagents and Controls are not expired. 2. Indicate Corrective Actions if QC fails at the bottom of the form. 3. If no testing performed, indicate "No Patient Tests" 4. Questions: Point of Care Coordinator x7974 5. Completed Log is stored in the Lab.
MONTH: _____ YEAR: _____	
LAB REVIEW POCC INITIALS: _____ DATE: _____	**Monthly Calibration bar inspection/cleaning** Date _____ Initials _____

URINE MULTISTIX® Lot #: _____ Exp: _____

LOT	DAY OF THE MONTH	QC Reagent	LEVEL 1 Lot #: _____ Exp: _____ ✓	LEVEL 2 Lot #: _____ Exp: _____ ✓	Maintenance of test table, insert, & meter *Cleaned and Disinfected* ✓	QC Pass? *QC/Reagents not expired* ✓	Temp (°C) *Acceptable Range* 18-30 °C	Humidity (%) *Acceptable Range* 18-80%	Operator Initials
	1.								
	2.								
	3.								
	4.								
	5.								
	6.								
	7.								
	8.								
	9.								
	10.								
	11.								
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	23.								
	24.								
	25.								
	26.								
	27.								
	28.								
	29.								
	30.								
	31.								

QC FAIL? CORRECTIVE ACTIONS: (Indicate below: e.g. Check exp. dates, repeat, try new reagent / QC. Contact lab with repeated fails)

_____

_____

_____

_____

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**WHOLE BLOOD PT/INR USING THE ROCHE COAGUCHEK XS PLUS METER**
Purpose:	To provide an accurate and reliable method to monitor oral anticoagulant therapy in the point of care setting.
Supportive Data:	Point of Care The CoaguChek XS Plus is a CLIA waived system. Roche Technical Support: 1-800-428-4674. www.coaguchek.com
Equipment:	CoaguChek XS Plus meter CoaguChek XS PT test strips CoaguChek XS PT test strip code chip (from same box as test strip) CoaguChek XS Plus Liquid Controls CoaguChek XS Plus Liquid Control code chip Lancet (at least 1.8mm depth) Alcohol wipe or soap and water Gauze or tissue Bandages
Authorized to Perform:	Registered Nurse (RN), License Vocational Nurse (LVN), Medical Assistant (MA)

A. **INTRODUCTION/PRINCIPLE:**

1. Prothrombin Time (PT) is a test of the blood's ability to clot. Blood clots form in response to vessel injury to prevent excessive loss of blood. If blood clots form inappropriately and lodge in the vascular system of important organs, serious consequences such as stroke can result. In certain medical conditions (i.e. atrial fibrillation or mechanical heart valves) blood clots are more likely to form, and there is increased risk of stroke. Oral anticoagulants are used to prevent clots in these conditions.
2. Oral anticoagulants have a narrow therapeutic range and the response to a standard dose varies widely both between patients and within a patient over time. Patients undergoing oral anticoagulant therapy must have their level of anticoagulation monitored often. Dosage adjustments should be made as needed to ensure maximum safety and efficacy.
3. The PT test is the principle assay used to monitor oral anticoagulant therapy. The dosage of oral anticoagulant is adjusted based on the PT test results to recommended therapeutic ranges. The PT can be reported in seconds or as an International Normalized Ratio (INR). The INR is a mathematical conversion that compensates for differences between PT methods.
4. The CoaguChek XS Plus test strip and meter will provide an electrochemical measurement of Prothrombin time following activation of blood coagulation with human recombinant thromboplastin. In simple terms, blood works with the chemicals in the test strip to make a small electric current in the test strip that measures blood-clotting time.

B. **SPECIMEN:**

1. Requirements:
   a. Fresh capillary whole blood or fresh venous whole blood drawn in an anticoagulant-free plastic syringe.
   b. The blood sample must be applied to the test strip within 10 minutes of removing the strip from its container.
   c. Capillary sample must be applied to the strip within 15 seconds of the fingerstick.
   d. Minimum sample size is 10 uL of blood.
2. Criteria for rejecting specimens:
   a. Plasma or serum cannot be used.
   b. Sample size cannot be less than 10 uL.

Department Review	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Department of Pathology	Pharmacy ~~and~~ & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
05/13, 11/17, 05/20	06/13, 12/17, 06/20	06/13, 01/18, 07/20	04/18	n/a	07/13, 04/18, 09/20	10/20	08/13, 05/18, n/a	08/13, 05/18

c. Additional blood sample must not be added to the test strip once testing has begun.
d. Meter will beep to indicate that sufficient flood has been applied and that testing has begun.
e. Venous sample cannot be collected in a syringe containing anticoagulant, or into a glass tube or syringe.
f. Sample must be used immediately after collection.
g. Do not collect from an arm receiving an infusion line for intravenous (IV) therapy.

3. Collecting a Fingerstick Sample:
   a. Prepare lancet device according to manufacturer's instructions. Set it aside until finger puncture is needed.
   b. Warm the hand by having the patient hold it under their arm, using a hand warmer, or washing with warm water.
   c. If possible, have the patient hold his or her arm down to the side, so the hand is below the waist, for about 30 seconds to increase blood flow.
   d. Massage the finger from its base.
   e. Clean the selected finger with alcohol wipe or use soap and warm water. Allow to air dry completely.
   f. Prepare the meter.
   g. When the meter displays the flashing test strip and blood drop symbols, with the hand still down, stick the side of the finger with a lancet. Do not wipe away the first drop of blood. Do not puncture the finger until the flashing test strip and blood drop symbol appears on the meter screen.
   h. Gently squeeze and release the finger from the base to develop a hanging drop of blood.
   i. Blood should be applied within 15 seconds of the puncture. Do not touch the strip with the finger. Do not apply a second drop or disturb the strip while testing.
   j. While the flashing test strip and drop of blood symbols are flashing on the display, apply the first drop of blood as outlined in Performing a Test Procedure.

C. **STORAGE AND STABILITY:**

1. Store test strips in their container, with the cap closed.
2. Store test strips at room temperature or in the refrigerator (2-30 °C or 36-86 °F).
3. When stored properly, the test strips can be used until the expiration date printed on the test strip container.
4. Store test strips in a cooler with an ice pack when transporting in a car.
5. Dispose of strips past their "use by" date.
6. Use the test strip within 10-minutes after removing it from the container.
7. Do not open a vial of test strips or touch a test strip with wet hands or gloves. This may damage the test strips.
8. Close the container tightly.
9. A blue color on the back of the test strip indicated storage conditions have been maintained. A lavender or purple color indicates that storage conditions have been exceeded. Do not use and dispose of any test strips with a lavender or purple color on the back.

D. **OPERATING CONDITIONS**

1. Temperature: Use between 59°F and 90°F **(15°C and 32°C)**. **Relative** Humidity: Use between 10-85%.
2. Use only fingertips on touchscreen.
3. Place on level, vibration-free surface while testing.
4. Do not use near strong magnetic fields.

E. **METER SET-UP (CHANGES FROM DEFAULT SETTINGS)**

1. Lockouts > QC > New Code > YES

F. **QUALITY CONTROL:**

1. The CoaguChek XS System has quality control functions integrated into the meter and test strips; two levels of QC are automatically run with every patient test. If the QC results are acceptable, the patient results will display.
2. Liquid controls must be performed on each new shipment and lot of test strips. Record results on the Quality Control Log.

G. **PROCEDURE:**

1. Before Testing:
   a. A code chip is required for each lot of test strips. The XS Plus meter will store data from 60 code chips.
   b. Leave the code chip in the meter to protect the electrical contacts.
   c. Inserting the Code Chip:
      i. Be certain the meter is Off.
      ii. Remove the old code chip and throw it away.
      iii. Make sure the 3-number code on the new test strip container matches the 3-number code on the new code chip.
      iv. Insert the code chip into the code chip slot on the meter with the printed side facing up it snaps into place.
2. Performing a test:
   a. Use hand hygiene.
   b. Prepare the lancet device according to manufacturer's instructions.
   c. Place meter on a flat surface, free of vibrations, or hold it so it is roughly horizontal.
   d. Turn the meter on using the power button.
   e. The main menu will be displayed. Check the battery level (if there are no bars left in the battery symbol, it is not possible to perform any more tests). Check that the date and time are correct.
   f. Select 'Patient Test'.
   g. Enter the patient ID, then press OK. Select the patient from the list, or select 'New Patient' and enter a patient ID.
   h. The test strip symbol prompts staff to enter a test strip. Remove a test strip from the container and close the container tightly. Hold the strip so the print is facing upward. Slide the strip into the test strip guide in the direction indicated by the arrows. Slide it in as far as it will go. A beep tone indicates the meter has detected the strip.
      i. If this is a new lot of test strip, it is necessary to run liquid QC first. Refer to Performing Liquid Quality Control procedure.
   i. An hourglass symbol shows that the meter is warming (approximately 30 seconds).
   j. When the meter is ready, the flashing test strip and blood drop symbols appear. The meter begins a countdown, staff have 120 seconds to apply blood to the test strip. Do not obtain sample until the flashing test strip and drop of blood appear on the display. Strip must be used within 10 minutes of removing it from the container.
   k. Identify the sample target area on the test strip.
   l. Collect the fingerstick blood sample as outlined in "Specimen":
   m. Do not wipe away the first drop of blood.
   n. Apply the first drop of blood to the top or side of the target area within 15 seconds of puncture. Do not touch the strip with the finger.
      i. Note: dose the target area by bringing the patient's finger to the top of the test strip, or keeping the meter level, by bringing the meter to the patient's finger so that the side of the test strip touches the blood drop. Do not apply a second drop. Do not touch strip while a test is in progress.
      ii. Be certain that blood covers the sample target area completely.
      iii. The meter beeps when it detects the drop. The flashing blood drop symbol disappears. Do not add more sample. Do not touch the test strip or move the meter until the result is displayed.
   o. Wait for results—this takes about one minute.

p. If retest is necessary, use a new fingerstick from the opposite hand and a new test strip.
q. Read and record results. Remove the test strip.
r. Turn the meter Off.
s. Dispose of materials in biohazard or sharps container.

3. Performing Liquid Quality Control:
   a. Remove control vials from the fridge.
   b. Open the lid of the control bottle and remove the rubber cap.
   c. Hold the dropper with the sealed dropper neck pointing upward, then cut off the end of the cap with scissors. Ensure dropper is away from face to prevent contamination. Do not squeeze the bulb of the dropper while cutting the tip.
   d. Apply gentle pressure to the reservoir to transfer the entire contents of the dropper to the bottle. Make sure the dropper does not come in contact with the dried control plasma.
   e. Close the bottle. Keep the dropper at hand.
   f. Swirl the bottle using a circular motion to completely dissolve all the control plasma inside. Do not shake the bottle or turn it on its side. The solution is not ready to be applied to the test strip. (Controls may be used up to 30 minutes after reconstitution.)
   g. Turn the meter on. Check the battery level, date, and time.
   h. Select QC Test.
   i. Remove a test strip from the container, close the container, and insert the test strip into the meter.
      i. If using a new test strip lot and have not inserted the test strip code chip, do so now.
      ii. If using a new control lot, insert the code chip that came with the control solution.
   j. Select the code already stored for control or select New Code to use a new control solution.
   k. Select the level for this measurement.
   l. The hourglass will appear while the strip is warming.
   m. When the strip and dropper symbol display, apply the sample. Staff ~~have~~ **has**120 seconds to complete this step.
      i. Using the dropper, draw up the dissolved contents of the vial.
      ii. Apply a single drop of solution to the test strip. Enough sample is applied when the meter beeps.
   n. The result will be displayed and saved to memory.
   o. If liquid QC test fails, an arrow will be displayed and flash. Repeat first with the same control and a new test strip. If the control still fails, repeat with a new vial of control. If control continues to fail, contact the laboratory.
   p. Remove the test strip and turn the meter off.

4. Recalling Results:
   a. From the main menu, select 'Memory'.
   b. Select 'Patient Result' or 'QC Result'.
   c. Scroll through the data using the up and down arrows. The most recent test is listed at the top.
   d. Select a result. The patient ID, test result, date and time of test, and strip code is displayed.
   e. If the 'individual' symbol is selected, only results for this patient will be displayed.

5. Cleaning the Meter:
   a. Use only 70% isopropyl alcohol or 10% bleach to clean the meter housing:
      i. With the meter turned OFF, ensure the blue test strip guide cover remains tightly closed while cleaning the housing.
      ii. Make sure no liquid enters the meter or accumulates near any opening.
      iii. Let the disinfectant sit on the meter for at least two minutes for alcohol wipes and five minutes for bleach wipes.
      iv. Wipe away residual moisture and fluids after cleaning the housing.
      v. Allow wiped areas to dry for at least 15 minutes before performing a test.

b. Use only 70% isopropyl alcohol or 10% bleach to clean the test strip guide upon opening a new bottle of test strips. Use of any other cleaning solutions can result in damage to the meter or incorrect patient results.
c. With the meter turned off, open the cover of the test strip guide by pressing its front edge upward.
d. Move the cover safely away from the meter. Then rinse the cover with water or wipe it clean.
e. Hold the meter upright with the test strip guide facing down. (This will help prevent fluid from entering the meter.) Clean the easily accessible areas of the test strip guide with a cotton-tipped swab. Ensure the swab is only damp, not wet. Caution: do not insert any objects into the test strip guide. Doing so could damage the electrical contacts behind the test strip guide. Wipe the test strip guide area. Let the cleaning solution sit for at least one minute.
f. Wipe away any residual moisture and fluids. Let the inside of the test strip guide dry for at least 15 minutes with the cover off.
g. Close the cover. Make sure it snaps into place.

6. Troubleshooting:
   a. If the meter displays a message other than a result, refer to the Error Messages section of the CoaguChek XS Plus System User Manual.
7. Calculations: n/a
8. Expected values/reference range/critical values:
   a. Normal Range:
      i. The CoaguChek XS meter displays results in units equivalent to those used for the laboratory plasma measurements.
      ii. Normal, healthy, warfarin free individuals: 0.9 – 1.0 INR
   b. Therapeutic Range: must be determined by the physician/Allied Health Professional (AHP) for each patient based on the reason for anticoagulation therapy and how each patient responds to treatment.
      i. Less intense 2.0-3.0 INR
      ii. More intense 2.5-3.5 INR (mechanical heart valves, etc)
   c. Reportable range:
      i. The meter will display results 0.8 – 8.0 INR.
      ii. Any INR greater than or equal to 3.1 must be verified by the laboratory.
   d. Unexpected results:
      i. If the meter displays an unusual test result, check the strip code, date, and time programmed into the meter.
      ii. Repeat the test with a new fingerstick and test strip. If the result is still unexpected, draw a sample for the laboratory.
   e. Limitations:
      i. This method should not be used for patients being treated with Hirudin.
      ii. Hematocrit ranges between 25-55% do not significantly affect test results.
      iii. The presence of anti-phospholipid antibodies (such as lupus Ab) can lead to prolonged clotting times. Test using a lab APA-insensitive method.
      iv. Do not use the meter near strong electromagnetic fields.
      v. Results are unaffected by heparin levels up to 0.8U/mL and low molecular weight heparin levels up to 2 IU anti-factor Xa activity/mL.
      vi. Failure to follow cleaning procedures correctly can lead to a falsely elevated result.
   f. Reporting results:
      i. Record the result in the patient's chart.
      ii. Record the result on the XS Plus Patient Test Log (for regulatory requirements).

H. **REFERENCE(S):**

1. Roche Diagnostics. CoaguChek XS PT Test Product Insert. 7/2010. 05967716001 (02).

2. Roche Diagnostics. CoaguChek XS Plus System Policies and Procedures. 2007. 05021499001-00-0807.
3. Roche Diagnostics. CoaguChek XS Plus System User Manual. 05021464001 (02) 2009-11 USA.
4. Roche Diagnostics. CoaguChek XS Plus System Policy and Procedure manual CD 2012.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATION

ISSUE DATE: 06/94 **SUBJECT: Parking Program**

REVISION DATE: 09/02; 03/03, 07/04; 12/05; 04/08 09/10; 08/14, 06/17 **POLICY NUMBER:** 8610-261

Administrative Content Expert Approval:	~~04/20~~07/20
Administrative Policies & Procedures Committee Approval:	~~05/20~~08/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~06/20~~10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/20

A. **PURPOSE:**

1. To provide adequate parking for patients and visitors by defining Tri-City Healthcare District's (TCHD) parking program.

B. **POLICY:**

~~1. All employees and physicians are required to complete a parking application form.~~
~~a. The parking application form details their mode of transportation and identifying characteristics.~~
~~i. Employees shall submit a completed and/or revised form to Human Resources.~~
~~ii. Physicians shall submit a completed and revised form to the Medical Staff Office.~~

~~2.~~**1.** All TCHD Board Members, Medical staff, Executives, Directors and authorized administrative staff may park in the Medical Staff parking area.

~~3.~~**2.** Employees shall park in designated employee parking areas (Refer to Tri-City Healthcare District Parking Map).
   a. Employees or others who use a bike as their mode of transportation shall park and secure bikes in the designated bike parking areas.
   b. Volunteers may park either in reserved volunteer parking areas or in employee parking areas.

~~4.~~**3.** Construction personnel shall receive parking instructions from the Engineering Department during their orientation.

~~5.~~**4.** Non-compliance with parking standards results in the issuance of a Security Department Parking Violation.
   a. The department manager shall be notified if an employee receives a second parking violation. Corrective action follows Administrative Policy, Coaching and Counseling for Performance Improvement.

~~6.~~**5.** Valet services are provided to all District residents with a District benefit card. Valet services are provided Monday – Friday during designated hours and may be used for special events with notification one week prior to event.

~~7.~~**6.** The designated speed limit on campus is 15 MPH unless posted otherwise.

~~C. FORM(S):~~
~~1. Parking Permit Application~~

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

1. Tri-City Healthcare District Parking Map

Tri-City Medical Center
Oceanside, California

Employee Health and Wellness ~~Policy Manual~~

ISSUE DATE: 07/~~2006~~ **SUBJECT: Accident Investigation**

REVISION DATE: 07/~~2006~~, 05/~~2008~~

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**08/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/08**

A. **PURPOSE**

1. The intent of an accident investigation should be to determine the root cause of the accident so that proper controls/corrective actions can be implemented in order to prevent a recurrence.

B. **PROCEDURE**

1. ~~Prompt I~~investigation by supervisor/manager **immediately upon**~~within 48 hours of~~ knowledge of the accident.
2. ~~Regularly C~~communicate accident investigation information to Employee Health Services **within 24 hours**, through the submission of the Injury/Illness Investigation Report and Supervisors' Report of Employee Incident.
3. **Manager/Supervisor c**~~C~~ollect and preserve sources of evidence **including any equipment or machinery part that is suspected of failure, malfunction, misfit, or faulty design** at the scene. Secure and label any defective equipment to be removed from department, while maintaining chain of custody for future use. Equipment to be stored in secured location.
4. Observe and identify underlying factors/symptoms:
   ~~a. Any equipment or machinery part that is suspected of failure, malfunction, misfit or faulty design~~
   ~~b.~~**a.** Use of unsafe work practices or violation of safety policy and procedures
   ~~c.~~**b.** Human dimension factors, management issues
   ~~d.~~**c.** Procedural implications – processes and/or environmental conditions unsafe.
5. Determine the root cause(s), apparent causes and contributing factors
   a. If corrective action is necessary, report to appropriate persons/department (i.e., Engineering).

C. **RESPONSIBILITIES:**

1. **Managers/**Supervisors
   a. Investigate accidents promptly and thoroughly
   b. Call for assistance when needed
   c. Take corrective actions
2. Employee Health Services
   a. Assist supervisor with investigation when requested
   b. Follow-up on initial receipt of accident investigation report
   ~~c.~~**a.** Follow-up with Director/Manager 30 days following accident investigation to determine what, if any, corrective action and/or counseling was completed.
3. **Human Resources**
   a. Follow-up with Director/Manager 30 days following accident investigation to determine what, if any, corrective action and/or counseling was completed.

~~3.~~**4.** Employee

i. Cooperate with supervisors and others during investigations.

~~4. Manager/Supervisor Guide Sheet~~

~~a. If immediate notice of a serious injury is received:~~

~~i. Ensure injured employee receives appropriate medical care immediately~~

~~ii. Maintain concern for the employee's well-being~~

~~iii. Talk with co-workers if a serious injury has occurred~~

~~iv. Promptly appraise how serious the accident could have been and how likely it is to occur again~~

~~v. Depending on the type and extent of the accident, it will be important to isolate the scene and initiate preventative actions to avoid additional injuries.~~

~~b. Upon receipt of assignment:~~

~~i. Make contact with injured employee and schedule an interview within 48 hours of knowledge of injury.~~

~~1) (NOTE: All Injury/Investigation Reports are to be completed immediately after an injury occurs.)~~

~~ii. Meet with injured employee, complete appropriate accident investigation documents, and obtain signatures~~

~~1) Obtain detailed description of injury, with specific detail to:~~

~~2) All body parts injured and to what extent~~

~~3) Attempt to determine severity of accident/injury and document~~

~~4) If medical treatment is/was necessary~~

~~5) How did injury occur?~~

~~6) Exact location of accident with completion of diagram of scene~~

~~7) How could injury have been prevented?~~

~~8) Was faulty equipment cause of accident?~~

~~9) Witnesses to accident~~

~~10) If a result of lifting, twisting or turning?~~

~~11) Was accident a result of violation of safety policy and procedure?~~

~~12) If accident is a result of breach of safety policy, ensure the appropriate counseling to take place.~~

~~a) (NOTE: If repeat violations have occurred, appropriate counseling measures to be taken.)~~

~~13) Determine any witnesses and document~~

5. Director
   a. After investigation is completed by the Manager/Supervisor:
   b. The Director is to review the Supervisor's Report of Employee Incident and make any recommendations and/or document any significant information prior to signing form.
   c. Send accident investigation form to Employee Health Services.

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

1. **Accident Investigation** Manager/Supervisor Guide Sheet
2. **Injury/Illness Investigation Report**

Accident Investigation Manager/Supervisor Guide Sheet

1. If immediate notice of a serious injury is received:
   a. Ensure injured employee receives appropriate medical care immediately.
   b. Maintain concern for the employee's well-being.
   c. Talk with co-workers if a serious injury has occurred to prevent further occurrences.
   d. Promptly appraise how serious the accident could have been and how likely it is to occur again
   e. Depending on the type and extent of the accident, it will be important to isolate the scene and initiate preventative actions to avoid additional injuries.

2. Upon receipt of assignment:
   a. Make contact with injured employee and schedule an interview within 48 hours of knowledge of injury. (NOTE: All Injury/Investigation Reports are to be completed immediately after an injury occurs.)
   b. Meet with injured employee, complete appropriate accident investigation documents, and obtain signatures.
      i. Obtain detailed description of injury, with specific detail to:
      ii. All body parts injured and to what extent
      iii. Attempt to determine severity of accident/injury and document
      iv. If medical treatment is/was necessary
      v. How did injury occur?
      vi. Exact location of accident with completion of diagram of scene
      vii. How could injury have been prevented?
      viii. Was faulty equipment cause of accident?
      ix. Witnesses to accident
      x. If a result of lifting, twisting or turning?
      xi. Was accident a result of violation of safety policy and procedure?
   ~~a.~~c. If accident is a result of breach of safety policy, ensure the appropriate counseling to take place. (NOTE: If repeat violations have occurred, appropriate counseling measures to be taken.)
   d. Determine any witnesses and document.
   e. Once investigation is complete, give to Department Director for review.

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Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
Phone (760) 940-7270 - Fax (760) 940-4005

EMPLOYEE INJURY/ILLNESS INCIDENT REPORT

Note: This report is to be promptly and fully completed at the time of the injury or illness by employee and employee's supervisor or designee. A response to all questions is required unless otherwise indicated.

Employee's Name: _____ **DOB:** _____ **Gender: Male / Female**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Employee ID:** _____ **Hire Date:** _____

Position: _____ **Dept.:** _____

Status: Full Time: ___ 100 ___ .90 / **Part Time:** ___ .80 ___ .60 / **Per Diem** _____ (Please write average hours worked p/week)

EMPLOYEE

Date of Incident: _____ **Time Incident Occurred:** _____ a.m. / p.m.

Location (identify precisely): _____

Witnesses: _____

Name of other individuals involved: _____

Incident description (include specific description of employee's activities at time of incident): _____

Describe nature and severity of injuries: _____

Was the employee engaged in usual work when the incident occurred? (If not, specify position and date assigned): _____

Preexisting disability/condition contributing to incident? (Specify): _____

Identify physical/mechanical objects involved (tools, supplies, equipment, structures, etc. List manufacturer, model and serial no.): _____

BACK INJURIES ONLY: Were appropriate transfer techniques/lifting assists (Lift Team, Transfer Belt, Patient Lift, etc.) being used? **Please circle: Yes / No** If Yes, specify device: _____

Employee Signature: _____ **Date:** _____

8660-1001

SUPERVISOR

What recommendations do you have to prevent a reoccurrence of this type of incident? _____

What activities are you taking or do you intend to take to prevent a reoccurrence of this type of incident? _____

Does this area have a previous history of incidents? **Yes / No** If yes, indicate date of most recent incident and number of incidents in the past 12 months: _____

Does this employee have previous history of incidents? **Yes / No** If yes, indicate date of most recent incident and number of incidents in the past 12 months: _____

Have above physical/mechanical object been involved in a previous incident? **Yes / No** If yes, indicate most recent incident and number of incidents in the past 12 months: _____

Employee Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

INJURY PREVENTION REVIEW

Preventative Action Recommendations: _____

Corrective Actions Taken: _____

Manager Responsible: _____ **Date Completed:** _____

Employee Health: _____ **Date:** _____

Actions taken by Employee Health: _____

Tri-City Health Care District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS ~~Policy Manual~~

ISSUE DATE: 06/~~19~~99

SUBJECT: Employee Occupational Accident or Illness

REVISION DATE(S): 05/~~20~~08, 05/~~20~~11

Employee Health Department Approval:	06/20
Infection Control Committee Approval:	n/a
Environmental Health & Safety Committee Approval:	08/20
Medical Executive Committee Approval:	n/a
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure proper treatment to a **Tri-City Healthcare** District employee who sustains and occupational injury and/or illness.

B. ~~2.0~~ **DEFINITIONS:**

1. Occupational Injury/Illness – **is** an injury or illness that is caused **during the course of employment or arises out of employment.** ~~by your job or arises from your job.~~

C. ~~3.0~~ **PROCEDURE:**

~~3.1 The majority of industrial injuries and illnesses that employees suffer are not of life-threatening nature, but if an employee suffers an emergency, which shall mean, the sudden and unexpected onset of a condition requiring immediate medical or surgical care, he or she will have their condition stabilized by the District's emergency response teams and services offered in the Emergency Department. Heart attacks, cardiovascular accidents, hemorrhaging, fractures, and poisonings, loss of consciousness or respiration and convulsions are emergencies.~~

1. ~~3.2~~ Employees who incur an injury as a result of an occupational accident must **immediately** report **it to Department Leadership~~Manager/Supervisor~~ and complete an Employee Injury/Illness Incident. Department Leadership~~Manager/Supervisor~~ must complete supervisor's section on the Employee Injury/Illness Incident Report.** ~~to Employee Health Services.~~ The injured employee must **bring the completed Employee Injury/Illness Incident Report to Employee Health and must** verbally inform his/her immediate supervisor before leaving their assignment to report to Employee Health Services.

~~3.3 Employees who are injured while working must also complete an Employee Injury/Illness Incident Report. The employee's supervisor or manager will ensure that the Employee Injury/Illness Incident Report is completed and must include the employee's signature on the report. The Employee Injury/Illness Incident Report will then be sent to Employee Health Services. Work-related illness and exposure to a potential illness requires the same procedure as it followed for accidents.~~

2. ~~3.4~~ If an employee is injured during periods of time when Employee Health Services is closed and the employee is unable to complete his/her shift, the employee should be evaluated ~~in the~~ **at TCHD preferred occupational provider** ~~Emergency Department~~ before the employee is sent home. The injured employee must contact Employee Health Services the next business day.
   a. **Employee Health Services hours are as follows: Monday – Friday, 7:30 AM to 4:00 PM.**

3. ~~3.1~~ **The majority of industrial injuries and illnesses that employees suffer are not of life-threatening nature, but if an employee suffers an emergency, which shall mean, the sudden and unexpected onset of a condition requiring immediate medical or surgical care,**

the employee will have their condition stabilized by the Tri-City Healthcare District's emergency response teams and services offered in the Emergency Department. Heart attacks, cardiovascular accidents, hemorrhaging, fractures, and poisonings, loss of consciousness or respiration and convulsions are emergencies.

~~2.4.~~ ~~3.5~~ Any employee who is advised by the Emergency Department provider or the Employee Health Nurse to report to a consulting provider, or to return home as a result of a work injury or illness, **MUST FIRST** inform his/her supervisor before leaving the Medical Center grounds.

a. ~~Employee Health Services hours are as follows: Monday – Friday, 7:30 AM to 4:00 PM.~~

b. 3.6 The Emergency Department replaces Employee Health Services as the occupational injury treatment site on nights, weekends, holidays, and on infrequent occasions during scheduled Employee Health Service hours.

~~3.5.~~ ~~3.7~~ The Employee Health Nurse will be advised of all accidents, illnesses and potential illness, to ensure that appropriate treatment is being rendered.~~, and that the employee is free from communicable disease. This procedure of reporting and advisement will additionally serve in defining work vs. non-work circumstances. Following definition and the recording of circumstances, appropriate payment for treatment and compensation will take effect.~~

a. ~~3.8~~ If an employee is absent from work due to an industrial injury, ~~he or she~~**the employee** must have a written statement from a physician advising that it is necessary for the employee to refrain from work for a specific period of time. ~~After receiving verification of injury, Employee Health Services will submit an "Employer's Report of Occupational Injury or Illness" to the Worker's Compensation Carrier within five working days.~~

b. ~~3.9 Employees must indicate on their time card any time away from scheduled work hours due to an injury/illness as "PTO-Work Comp".~~ In an employee's absence, the employee's **Department Leadership~~manager/supervisor~~** is responsible for insuring appropriate time card documentation.

D. **ACCIDENT INVESTIGATION:**

1. ~~4.1~~ **Department Leadership~~Manager/Supervisor~~** ~~An accident investigation~~ must ~~be~~ complete~~d~~ **an accident investigation** ~~by the injured employees supervisor/manager within 48 hours~~ **upon** ~~of~~ knowledge of the accident. The intent of the accident investigation is to determine the root cause of the accident so that proper controls/corrective actions can be implemented in order to prevent a recurrence. Refer to **Employee Health and Wellness** Accident Investigation.~~, Health and Safety # 400.7.~~

E. **FORM(S)~~ATTACHMENT~~:**

1. ~~4.1~~ Employee Injury/Illness Incident Report

Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056
Phone (760) 940-7270 - Fax (760) 940-4005

EMPLOYEE INJURY/ILLNESS INCIDENT REPORT

Note: This report is to be promptly and fully completed at the time of the injury or illness by employee and employee's supervisor or designee. A response to all questions is required unless otherwise indicated.

Employee's Name: _____ **DOB:** _____ **Gender: Male / Female**

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Employee ID:** _____ **Hire Date:** _____

Position: _____ **Dept.:** _____

Status: Full Time: ___ 100 ___ .90 / **Part Time:** ___ .80 ___.60 / **Per Diem** _____ (Please write average hours worked p/week)

EMPLOYEE

Date of Incident: _____ **Time Incident Occurred:** _____ a.m. / p.m.

Location (identify precisely): _____

_____

Witnesses: _____

Name of other individuals involved: _____

Incident description (include specific description of employee's activities at time of incident): _____

_____

_____

_____

_____

Describe nature and severity of injuries: _____

_____

_____

Was the employee engaged in usual work when the incident occurred? (If not, specify position and date assigned):

_____

Preexisting disability/condition contributing to incident? (Specify): _____

_____

Identify physical/mechanical objects involved (tools, supplies, equipment, structures, etc. List manufacturer, model and serial no.): _____

_____

BACK INJURIES ONLY: Were appropriate transfer techniques/lifting assists (Lift Team, Transfer Belt, Patient Lift, etc.) being used? **Please circle: Yes / No** If Yes, specify device: _____

Employee Signature: _____ **Date:** _____

8660-1001
(Rev. 4/09)

SUPERVISOR

What recommendations do you have to prevent a reoccurrence of this type of incident? _____

What activities are you taking or do you intend to take to prevent a reoccurrence of this type of incident? _____

Does this area have a previous history of incidents? **Yes / No** If yes, indicate date of most recent incident and number of incidents in the past 12 months: _____

Does this employee have previous history of incidents? **Yes / No** If yes, indicate date of most recent incident and number of incidents in the past 12 months: _____

Have above physical/mechanical object been involved in a previous incident? **Yes / No** If yes, indicate most recent incident and number of incidents in the past 12 months: _____

Employee Signature: _____ **Date:** _____

Supervisor Signature: _____ **Date:** _____

INJURY PREVENTION REVIEW

Preventative Action Recommendations: _____

Corrective Actions Taken: _____

Manager Responsible: _____ **Date Completed:** _____

Employee Health: _____ **Date:** _____

Actions taken by Employee Health: _____

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS SERVICES~~Policy Manual~~

ISSUE DATE: 06/~~19~~99 **SUBJECT: Ergonomic Policy**

REVISION DATE: 07/~~20~~06, 05/~~20~~08, 05/~~20~~11

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**08/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/11**

A. **PURPOSE:**

1. Tri-City Healthcare District (TCHD) has adopted this ergonomic policy to minimize repetitive motion injuries associated with employment activity.

B. **DEFINITION(S):**

1. **Workforce Member: Workforce Members, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **MANAGEMENT COMMITMENT AND EMPLOYEE INVOLVEMENT:**

1. Commitment and involvement are essential elements of a sound safety and health program.
2. Commitment by management provides the organizational resources and motivating force necessary to deal effectively with ergonomic hazards.
   a. Management demonstrates involvement by ~~placing a priority on~~ eliminating ergonomic hazards by conducting training and risk assessment education.
   b. An effective program for job safety, health and ergonomics is in place and communicated to all ~~employees~~**Workforce Members**. This program includes policies and procedures regarding:
   c. Orientation of employees, including education in injury prevention
   d. Continuing injury prevention education
   ~~e. Transitional Return to Work programs~~
   ~~f.~~**e.** Compliance with transfer and lift procedures
   ~~g.~~**f.** Procedures for reporting of early signs and symptoms of injuries
   ~~h.~~**g.** This written program is reviewed and updated ~~at least annually and whenever~~ **as** necessary to reflect new or modified tasks and procedures that affect worker exposure to ergonomic hazards.
3. ~~Employee~~ **Workforce Member** involvement in the ergonomics program is encouraged **including by not limited to:**
   ~~3.~~ ~~contact with the Area Safety Representatives,~~
   a. Prompt and accurate reporting of injuries,
   b. Establishment of safety and health committees~~, and~~
   ~~4.~~**c.** Training of ~~employees~~**Workforce Members** in the skills necessary to analyze jobs for ergonomic stress.

~~5.~~**4.** Procedures are implemented to regularly evaluate the effectiveness of the ergonomics program and to monitor success in meeting goals and objectives. This process includes review of recorded OSHA 300 injuries, workers compensation and insurance reports, and reports from

employees**Workforce Members**. ~~Also included are regular walk-through inspections and safety department meetings.~~

~~6.~~5. **Erognomic assessments**~~Work site analyses~~ are ~~preformed~~**performed** ~~on an~~ as-needed bas**ed on**~~is~~. ~~High risk work assignments, high injury volume, or~~ specific requests by **department Leader or designee**~~employees or physicians are the determining factors~~.

~~7.~~6. **Department Leader**~~Employee Health Services Manager~~ will coordinate ordering equipment

D. **HAZARD PREVENTION AND CONTROL:**

1. Ergonomic hazards are prevented primarily by proper selection of equipment, effective use of assistive devices, and by implementation of proper work practices.
2. **Department Leaders**~~Supervisors~~ are familiar with ergonomic guidelines and enforce the institutional policies.
3. Injuries are accurately recorded on the OSHA 300 form by Employee Health Services.

~~4. The Lift Team is to be utilized during hours of operation. Staff receives training for proper patient transfer and lifting techniques including the use of assistive devices.~~

~~E. **MEDICAL MANAGEMENT**~~

~~1. Proper medical management is necessary both to eliminate and reduce the risk of injuries through early identification and treatment through rehabilitation and training. Employee Health Services will provide and coordinate medical evaluation surveys that will help to identify, reduce and prevent Repetitive Motion Injuries. Health care providers must be part of the injury prevention team and, after on-site review, regularly interact and exchange information with the management.~~

~~F.~~E. **TRAINING AND EDUCATION:**

1. The purpose of training and education is to ensure the **Department Leaders**~~managers, supervisors~~ and ~~employees~~**Workforce Members** are sufficiently informed about the ergonomic hazards to which they may be exposed and thus are able to participate actively in their own protection.

~~2. All employees will receive annual training to help identify potential ergonomic risks with work activity.~~

~~3.~~2. The orientation/new employee program includes training in **body mechanics, proper lifting techniques, workstation ergonomics,**~~:~~ **and training and proper use of lifting equipment.**

~~a. Ergonomic principles for both lifting and computer use.~~

~~b. Use/purpose for the Lift Team.~~

~~c. Training in appropriate use of mechanical devices specific to that employee's work assignment.~~

~~4.~~3. Annual training is provided and addresses specific needs through Computer Based Learning.

~~G.~~F. **RELATED DOCUMENT(S)~~ADJUNCT RESOURCES~~:**

1. Administrative Policy: ~~#477,~~ Employee Health and Safety
2. **Employee** Health **Services**~~and Safety Practice Manual 400.1,~~: Injury Illness Prevention Program
3. **Employee** Health **Services**~~and Safety Practice Manual 400.3,~~: Light Duty
4. **Patient Care Services Policy:** Lift Team Policy~~, Patient Care Services Manual~~
5. **Environment of Care Manual/**Safety **Management** Policy ~~#1040,~~: ~~"~~Risk Assessment Program~~"~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
INTERDEPARTMENTAL COORDINATION

~~TRI-CITY MEDICAL CENTER~~ ~~Engineering Policy & Procedure~~	~~Section: ENGINEERING DEPARTMENT~~ ~~Subject: Radiation Protection Regulation Guidelines~~ ~~Policy Number: 9000 Page 1 of 2~~
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/1/87~~ ~~REVISED: 3/97; 5/00; 5/03; 6/06; 5/09; 6/12~~

SUBJECT: Radiation Protection Regulation Guidelines

ISSUE DATE: 11/87
REVIEW DATE(S):
REVISION DATE(S): 3/97, 5/00, 5/03, 6/06, 5/09, 6/12

Department Approval ~~Date(s)~~:	**03/20**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**03/20**
Department of Radiology Approval:	**09/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s)~~:	

~~A.~~ ~~**REFERENCES:**~~

1. ~~State of California Department of Health, "Guide for the Preparation Applications for Medical Programs, RH 2010".~~
2. ~~National Council on Radiation Protection and Measurements (NCRP) Report No. 48, "Radiation Protection for Medical and Allied Health Personnel."~~
3. ~~State of California Administrative Code, Title 17 Health, "California Radiation Control Regulations."~~

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

1. To provide protection guidelines for personnel who may occasionally come into contact with radioactive materials at the hospital.

~~C.~~**B. GENERAL:**

1. The safe use and handling of radioactive materials are easily accomplished when common sense is combined with basic radiation safety concepts. The following guidelines are basic protection rules intended for Engineering and other ancillary personnel who may occasionally come in contact with small amounts of radioactive materials or radiation areas.

~~D.~~**C. POLICIES:**

1. Do not handle any container which is marked **RADIOACTIVE MATERIAL** unless you have written procedures or instructions on how and when you may do so.
2. Containers marked **RADIOACTIVE MATERIAL**, which appear damaged and/or wet, should not

be handled until surveyed and inspected by trained personnel. Security personnel receiving packages or radioactive material during off-hours should refer to Policy/ Procedures 3103, "Receiving Radioactive Material: Guidelines for Security Personnel."

3. Any repairs which must be made in potentially contaminated surroundings and could result in the contamination of personnel performing the repairs must be made only after consulting with nuclear medicine, radiation therapy, or medical physics personnel. Nuclear medicine or radiation therapy personnel should be present during repairs in their respective departments or during repairs performed in rooms which contain patients receiving therapeutic amounts of radioactive material to see that contamination or unnecessary exposure of personnel does not occur.
4. Any repairs which must be made to the sanitary waste system from the following room (s) will require notification of the Radiation Safety Officer prior to proceeding with those repairs.
   a. Room 497
5. Personnel should not enter a patient's room which has been posted **RADIATION Area** or **RADIOACTIVE MATERIALS**, unless they have specific instructions to do so. Nothing is to be allowed to lease these rooms without specific instructions from either nuclear medicine, radiation therapy, or nursing personnel. Rooms will not be cleaned until after **RADIATION AREA** or **RADIOACTIVE MATERIALS** signs have been removed.

D. **REFERENCES:**

1. **State of California Department of Health, "Guide for the Preparation Applications for Medical Programs, RH 2010".**
2. **National Council on Radiation Protection and Measurements (NCRP) Report No. 48, "Radiation Protection for Medical and Allied Health Personnel."**
3. **State of California Administrative Code, Title 17 Health, "California Radiation Control Regulations."**

~~5.~~**6.**

Tri-City Health Care District	~~Distribution: RN's~~Home Health Care
PROCEDURE:	**LABORATORY PROCEDURES**
Purpose:	To define the parameters for laboratory procedures
Issue Date	**10/96**

A. **POLICY:**

1. No laboratory procedure is performed except on signed order of person lawfully authorized to give such an order. -Such an order may be given by telephone and is signed by the physician within 30 days. -Each order must be read back.
2. All telephone orders are received by a licensed nurse. -Prescriptions from MD given to patient may be used.
3. All signed orders are incorporated into the patient's medical record.
4. All laboratory tests ordered must be directly related to the management of specific symptoms or discomfort.
5. TCHC ~~RN's~~ nurses draw blood, ~~LVN's~~ obtain appropriate urine specimens for laboratory testing, and deliver to Tri-City Medical Center Laboratory or MD/insurance company required laboratory for analysis. ~~All Laboratories maintain CLIA laboratory certificate of accreditation, which is validated every 6 months through the performance improvement program at TCHC~~.
6. ~~Techniques for specimen collection and blood draw are consistent with the Marker Model Standards of Care/Procedure Manual.~~

B. **PROCEDURE:**

1. The nurse completes the appropriate lab requisition **with diagnosis code(s) supporting ordered laboratory test**. -The physician's name and **fax/**telephone number must be clearly indicated so that the lab can phone back test results.
2. The nurse selects necessary equipment. -Make sure all tubes are labeled with patient's name, **date of birth (DOB)**, date, time of collection, and RN's/LVN's initials in patient's presence.
3. ~~The specimen is collected from the patient as directed by the Marker Model Procedure Manual utilizing proper aseptic techniques.~~
4. **~~3.~~** The collected specimens are placed in plastic bags with ice, if needed, and transported in closeable, leak proof, puncture resistant container that is properly labeled with Biohazard Label.
5. **~~4.~~** ~~TCMC I~~Laboratory personnel phone/fax the attending physician with the results. -Confirming copies are sent to the attending physician and TCHC.
6. **~~5.~~** A properly executed consent form must accompany requests for HTLV III testing.
7. **~~6.~~** Document all laboratory procedures in the patient's medical chart.

C. ~~C.~~ **RESPONSIBLE PARTY:**

1. **~~8.~~** All RN's/LVNs ~~who are certified~~.

~~C. D. DISTRIBUTION: All RN's.~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~10/96~~	~~7/99, 8/00~~	~~8/98, 10/05, 10/07, 10/09, 8/12~~	

~~S:\homecare\Procedures Home Care Current\Laboratory Procedures.doc 8/17/12:gam~~

Department Review	Pharmacy & Therapeutics Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/98, 07/99, 08/00, 10/05, 10/07, 10/09, 08/12, 06/20	n/a	09/20	09/20	10/20	n/a	

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: NEW

SUBJECT: Medical Staff Funds & Medical Staff Representation by Legal Counsel

REVISION DATE:

POLICY NUMBER: 8710 – NEW

Medical Staff Department Approval:	**10/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	
Administration Approval:	
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **MEDICAL STAFF FUNDS**

1. Medical Staff funds, regardless from what source (i.e. medical staff dues, hospital funds) shall be under the sole control and oversite of the Medical Staff. All medical staff members may at all reasonable times copy and inspect all bank statements and the quarterly financial statements prepared by the Treasurer, Section 8.6-3. The medical staff and/or their elected representatives (MEC) must be notified of and provided with the opportunity to comment upon impending significant expenditures of medical staff funds of amounts which exceed $10,000.
2. Hospital provided funds, subject to District Board consideration and approval, shall be deposited into the Medial Staff account from the hospital to assure the medical staff the financial ability to solely administer those functions required under the bylaws[1]

B. **MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL**

1. Upon the authorization of the medical staff, or of the medical executive committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the hospital. The medical staff shall enter into a written engagement letter with the individual selected to be independent legal counsel affirming that the medical staff, not the hospital, is the counsel's client, that the counsel represents solely the interests of the medical staff, and the attorney-client privilege of confidentiality applicable to all communications between the counsel and the medical staff is held solely by the medical staff, regardless of whether the medical staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the medical staff that there will be no interference by the third party with the counsel's independence of professional judgment or with attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 3-310[2].

[1] This provision requires that any funds be granted to the medical staff by the hospital for medical staff operations are placed solely under the control of the medical staff. This assures the medical staff oversees and regulates the performance of officers, department chairs or others receiving a stipend for medical staff administration. It also assures that the hospital is not in a position to abuse its position as trustee of medical staff funds by sequestering those funds away from medical staff control, as occurred during the dispute that led to litigation between the medical staff of Ventura Community Memorial Hospital and the hospital's board of directors in 2002.

[2] This section is added to reflect the medical staff's right to retain legal representation as one of the rights of medical staff self-governance under SB 1325. See Business & Professions Code 2282.5(a)(5). See also section 10.3-2 Duties, "Duties" of the Medical Executive Committee, " enumerating duties of the MEC to affirmatively exercise and protect the medical staff's rights of self-governance.

Tri-City Medical Center
Oceanside, California

DELETE – combined with Security Policy: Delegated Authority

SECURITY
SECURITY ADMINISTRATIC

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 29, 1991~~ ~~Reviewed: 2/94, 9/97, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Accountability for Performance of Subordinates~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 103~~

SUBJECT: Accountability for Performance of Subordinates

ISSUE DATE: March 29, 1991
REVIEWED DATE(S): 2/94, 9/97, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13
REVISION DATE(S): 12/01, 7/03

Department Approval Date(s):	**02/20**
Environmental Health and Safety Committee Approval Date (s):	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

~~A. **PURPOSE:**~~
~~1. To establish supervisory accountability for all subordinates.~~

~~B. **POLICY:**~~
~~1. All supervisory personnel (Security Supervisor, Lead/Charge Security Officer) shall be held accountable for the performance of subordinate personnel under their immediate command.~~

~~C. **PROCEDURE:**~~
~~1. Supervisory staff on all shifts shall be expected to provide proper direction, coordination, and control of all subordinates~~
~~2. Direction shall be provided by either written or verbal means.~~
~~3. The responsible supervisor shall either directly or indirectly monitor coordination of any work effort. This in no way shall relieve the Security Supervisor of the responsibility for the final outcome.~~
~~4. Control shall be maintained over subordinate personnel with respect to conduct and final disposition.~~
~~5. Nothing in this policy shall make any Supervisory personnel responsible for actions of a subordinate, which are beyond acceptable policy and procedures or legal sanctions. This policy shall also apply to any acting or interim supervisory personnel.~~

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 04/92

SUBJECT: **Aero Medical Transport Responsibilities**

REVIEWED DATE(S): 02/94, 10/97, 09/01, 05/03 11/06, 03/09, 06/11, 07/15
REVISION DATE(S): 02/94, 9/01, 07/03, 05/11, 09/15

POLICY NUMBER: 223

Department Approval:	**07/15 05/20**
Environmental Health and Safety Committee Approval:	**08/15 08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**09/15 n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**

1. To provide guidelines for Security Department personnel while assisting with a Aero Medical Transportation upon the Medical Center campus

B. **POLICY:**

1. It is the policy of the Security Department to ensure that prompt and professional service is provided during an Aero Medical Transport.

C. **PROCEDURE:**

1. When the Security Department receives notification from the E.D. Radio Room or Charge Nurse in the Emergency Department of an incoming Aero Medical Transport, ~~the 3 Post~~ **an available** ~~O~~**o**fficer will respond to the Helicopter Landing Pad on the roof of the Emergency Department and complete the following; **make certain to ask if the transport is a rendeazvous or a patient pick-up**.
   a. The responding ~~O~~**o**fficer will report to the Landing Pad and activate the landing lights **regardless of time of day**.
   b. The Lead/Charge Officer **or if unavailable the responding security officer** will then contact the Central Plant Engineer and inform them of the ~~E~~**e**stimated ~~T~~**t**ime of ~~A~~**a**rrival.
   c. The ~~O~~**o**fficer will then await the arrival of the Aero Medical Transport agency.
   d. Once the Aero Medical Transport agency Helicopter is in sight, the ~~O~~**o**fficer will immediately shut down the air handlers for the Emergency Department.
   e. If the ~~H~~**h**elicopter is going to be on the ground for longer than fifteen minutes, the ~~O~~**o**fficer will contact the Central Plant ~~E~~**e**ngineer and ask them to turn the air handlers back on and will inform the ~~E~~**e**ngineer that they will ~~make contact~~ **provide an update** before take-off and re-shut down the air handlers.
   f. Once the Aero Medical transport is complete, the Lead/Charge Officer **or if unavailable the responding security officer** will make contact with the Central Plant ~~E~~**e**ngineer and inform them of the departure of the Helicopter.
   g. If the Aero Medical Transport arrives without acceptable notice, a detailed entry will be notated in the ~~O~~**o**fficer's D.S.R. with times and the names of the E.D. Radio Nurse and E.D. Charge Nurse. A notation will also be made in the Heliport Log stating no or little notice given.

~~g.~~**h. The heliport logbook will be updated regardless if acceptable notice was given or not. The following will be provided in to the logbook: agency's name, helicopter's tail number, reason for being on property, and times of arrival / departure.**

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 03/97 **SUBJECT:** After Action Incident Review and Debriefing

REVIEW~~ED~~ DATE~~(S)~~: 05/03, 11/06, 03/09, 06/11~~, 07/15~~ **POLICY NUMBER: 511**
REVISION DATE~~(S)~~: 07/03, 09/15

Department Approval:	**~~07/15~~05/20**
Environmental Health and Safety Committee Approval:	**~~08/15~~08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~09/15~~ n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**

1. To establish an action review process that will assist the Security Department in the formal review of all critical response situations or incidents involving Medical Center Security Officers.

B. **POLICY:**

1. In an on-going effort for continual improvement on the overall efficiency and effectiveness of services provided by the Security Department, an informal process for action review has been developed. This process will assist the Security Department in the identification, tracking, and trending of areas of service that are in need of improvement or modification. The Security Department will review all incident reports with Administration.

C. **PROCEDURE:**

1. Critical Situation/Incident – Any response by Security Department personnel, which include but are not limited to the following circumstances:
   a. Involving the Use of Force.
   b. Involving the arrest of an individual upon the Medical Center campus.
   c. Multiple Security Officer response or involvement
   d. Involvement of personnel from multiple Medical Center departments.
   e. Disaster (Drill/Actual)
   f. Any unusual event when it is determined by Security personnel that there is a need for documentation and additional review.

D. **FORM~~ATTACHMENT~~(S):**

1. ~~Security Department~~ After Action Incident Review form.

Tri-City Medical Center
Security Department

After Action Incident Review

The *After Action Incident Review* form is to be completed by Security Department personnel anytime a Security Officer feel that there is a process or incident that needs to be reviewed for the purposes of improvement within the Security Department.

Complete all applicable sections of this form and submit the completed *After Action Incident Review* with the completed Security Department Incident/Crime report. Use an additional continuation sheet if necessary.

1. Problem/Concern Identified including a Description of the Incident:

2. How was the Problem/Concern Identified:

3. Action Taken to resolve the Problem/Concern:

Recommendations:

Submitted By: _____ Date: _____ Received By: _____ Date: _____

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 21, 1994~~ ~~Reviewed: 1/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Arrest and Detention Authority~~ ~~Page 1 of 3~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 210~~

ISSUE DATE: January 21, 1994

SUBJECT: Arrest and Detention Authority

REVIEW DATE: 01/97, 05/03, 11/06, 03/09, 06/11, 05/13

POLICY NUMBER: 210

REVISION DATE: 07/03

Department Approval:	05/20
Environmental Health & Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines that all Medical Center Security Officers will properly maintain when involved with an arrest and detention of persons upon the Medical Center campus.

B. **POLICY:**

1. It is the policy of the Security Department that no Security Officer will make an arrest without first establishing probable cause for the arrest. The only exception will be in the event of a life-threatening emergency where the arrest is necessary to protect other Patients, Visitors, and Staff Members from bodily injury or death.

C. **PROCEDURE:**

1. All Security Department personnel are required to be familiar with the current laws of arrest, search, and seizure.
2. California Law states that Medical Center Security Officers have no greater powers of arrest than a private citizen.
3. The Penal Code defines an arrest as "the taking into custody of a person in a manner described by law by a Police Officer or Private Person". According to that definition, a person is considered to have been arrested when their freedom has been restricted through **unreasonable** detention.
4. Whenever possible Security Department personnel should summon the Oceanside Police Department to make arrests of persons from the Medical Center. Should the Oceanside Police Department not be able to respond in a timely manner, and it is in the best interest of the Medical Center, it will be the responsibility of the responding Security Officer to take the person into custody or make the arrest.

5. Under Penal Code Section 837, an arrest in California can be made by a private citizen only under the following circumstances.
   a. For a public offence committed or attempted in your presence.
   b. When the person arrested has committed a felony, although not in your presence.
   c. When a felony has been committed any you have reasonable cause to believe that the person arrested has committed the felony.
6. If it has been determined that an arrest is warranted and there is no threat of great bodily injury or death; the following will be followed.
   a. The person(s) will be asked to accompany the Security Officer to the Security Department Office.
      i. The responding Officer will request a second Officer to accompany them.
      ii. Once at the Security Office the person(s) will be informed that they are being placed under arrest.
      iii. If the person(s) is not cooperative the responding Officer will immediately implement section 3.7.
7. If the person is uncooperative the following will be immediately implemented.
   a. The person(s) will be taken into protective custody and placed into handcuffs.
   b. The person(s) will be informed that they are being placed under arrest and what they are being arrested for.
   c. Under no circumstances will any Security Officer use more force than is necessary to take the person into custody. All Security Department personnel will follow the Use of Force Policy when affecting an arrest.
   d. A search of the person will be conducted whenever a person is taken into protective custody or placed under arrest by any member of the Security Department. The Security Officer, pursuant to California Penal Code Section 837, will take any weapons or dangerous items into custody.
   e. The person(s) arrested will be moved to a neutral area if appropriate. The Security Department Office will be used to wait for Oceanside Police Department if possible.
   f. The Oceanside Police Department will be notified as soon as possible and informed of the arrest in order to respond to take the person into custody.
   g. The arrested person(s) and any seized property will be turned over to the Police Officer upon their arrival.
   h. As soon as the arrest has been made, the Security Supervisor, Designee, or Shift Lead Officer will be notified of the arrest and any information regarding the arrest.
   i. The primary Officer will complete a detailed Crime/Incident report including all available information regarding the arrest.
8. The Security Supervisor, Designee, or Shift Lead Officer will ensure that the appropriate Administrator or Administrative Coordinator is informed of the arrest and the circumstances of the arrest if necessary.
9. All Security Department personnel while acting in the capacity of a representative of the Medical Center will only have the authority to do so while within the boundaries of Tri-City Medical Center owned or operated properties and within the Tri-City Healthcare District approved Policies and Procedures.
10. If any Security Department personnel witness any actions by another who is off property and these actions are not life threatening or capable of bodily injury, the Officer will immediately request the PBX Operator to contact the appropriate Law Enforcement agency. The Officer will maintain a position of observation and only assist the Law Enforcement agency if requested to do so, or if it is necessary for the Officer's safety.
11. If a suspect has exhibited hostile or aggressive behaviors, attempted to commit a crime, or threatens the Safety, Security and Welfare or any Patient, Visitor, or Staff Member, but has not committed a crime, the suspect may be placed into protective custody for a **reasonable** amount of time to wait for the Oceanside Police Department to make contact with the subject, properly identify the subject, and check for warrants.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

ISSUE DATE: 11/93 **SUBJECT:** Authorized Security Department Uniforms and Safety Equipment

REVIEW~~ED~~ DATE~~(S)~~: 12/95, 10/97, 06/00, 02/01, 05/03, 06/09, 06/11~~, 07/15~~ **POLICY NUMBER: 401**
REVISION DATE~~(S)~~: 02/01, 07/03, 06/09, 09/15

Department Approval: ~~07/15~~05/20
Environmental Health and Safety Committee Approval: ~~08/15~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: ~~09/15~~ n/a
Board of Directors Approval: 09/15

A. **PURPOSE:**

1. To establish guidelines for the wearing and issuing of approved Security Department ~~U~~uniforms and ~~S~~safety ~~E~~equipment by all ~~S~~security ~~P~~personnel.

B. **POLICY:**

1. All on duty ~~M~~medical ~~C~~center Security Department ~~P~~personnel will wear only approved uniforms and safety equipment items while acting in the capacity of ~~S~~security ~~O~~officer. In addition, all uniform items are to be issued in accordance with this policy.

C. **APPROVED UNIFORM APPAREL:**

1. Required Uniform Items (Department Issue)
   a. Uniforms will be clean and pressed with visible vertical creases on the pant legs and on shirt sleeves.
   b. Boots will be clean and polished and all equipment will be maintained.
   c. A supervisor will routinely check uniforms and equipment to verify compliance.
   d. ~~Flying Cross Uniform~~ Trousers.
   e. ~~Flying Cross Short Sleeve~~ Shirt.
   ~~f. Flying Cross Long Sleeve Shirt.~~
      i. Long sleeve shirts are to be worn with a solid Blue Break-away tie and plain silver tie bar.
   ~~g.~~**f.** ~~Quartermaster brand "Law Pro" Law Enforcement~~ Jacket.
   ~~h.~~**g.** ~~All-American Military Style pull over v-neck type sweater~~.
   ~~i.~~**h.** Department patches are to be worn on both sleeves of any approved shirt, sweater, **and** jacket~~,~~ and in the center of management approved ball cap.
   ~~j.~~**i.** Department issued ~~S~~security badge will be displayed in plain sight in an appropriate manner.
   ~~k.~~**j.** Medical Center ~~P~~photographic ~~i~~identification ~~B~~badge will be worn in plain sight with the photograph showing.
2. Required Uniform Items (Officers expense).
   a. Duty Belt will be made of ~~N~~nylon with plastic buckle and black in color.
   b. Four Belt keepers matching duty belt.
   c. One Key Ring matching duty belt.
   d. Footwear will consist of any of the following and will be maintained in a clean and neat condition.

e. Military style boots, with plain toe, and full leather upper, black in color, and having plain type sole.
f. High Tech brand (or equivalent) style uniform boot, black in color with standard sole.
i. All low cut style footwear will be worn with plain black or dark blue colored socks. High top boots may be worn with white, black, or blue socks (~~S~~sock color will not be visible while wearing boots).
ii. 3.2.6.2 Prior approval from the Security Supervisor must be obtained for the wearing of any other style of footwear.

3. Optional Uniform Items (Officers expense)
a. Approved plain ~~N~~navy ~~B~~blue or ~~B~~black ball cap style ~~S~~security ~~H~~hat with approved ~~S~~security patch centered on the front.
b. Crew style tee shirt. Color will be Black, White, or Blue only.
c. The wearing of appropriate insignias. Insignias must be approved by the Security Supervisor prior to being worn and can only be worn in a manner displaying proper respect and protocol.

4. ~~Required~~ Safety Equipment (Department Issue)
a. One~~,~~ ~~N~~nylon pouch to carry personal protective equipment.
i. Nylon pouch to carry the following items. A) ~~Blue~~ non-latex medical exam gloves (or equivalent). B) ~~S~~safety glasses. C) ~~S~~spit sock.
b. Department furnished Two–Way Motorola ~~R~~radio.
i. Officer will be issued his own personal radio for use while on duty. The Officer will be solely responsible for maintaining his issued radio and keeping it in good operating condition. Any damage to the Officer's radio must be immediately reported to his supervisor. Damage due to neglect will be the responsibility of the assigned Officer.

5. Optional Safety Equipment (Officer expense)
a. Mini style flashlight with case matching duty belt.
~~b. EMT style equipment holder, matching duty belt.~~
~~c.~~**b.** Plain black colored gloves. Gloves will only be worn with uniform during night shifts or inclement weather.

6. While on duty, ~~S~~security ~~O~~officers will only wear the appropriate uniform items as described.
7. While on duty, Security Department ~~P~~personnel will only be allowed to wear the following personal affects:~~.~~ ~~A~~appropriate wristwatch. ~~R~~ring(s)~~,~~ to be limited to wedding band or one ring per hand **and not bulky or excessive or would not allow the officer to perform their physical-contact duties safely**. The wearing of any necklaces will be done in such a manner to be kept from plain sight. Earrings to be limited to stud type and one per ear (Females ~~O~~only).

D. ISSUANCE OF UNIFORMS:

1. Full Time New-Hire
a. Number of issued uniforms to be received by Full Time New-Hire Security Department Officers will be determined by the Security Manager based on Department needs.

~~2. Per Diem New-Hire~~
~~a. Number of issued uniforms to be received by Per Diem New-Hire Security Department Officers will be determined by the Manager based on Department needs.~~

~~3. Annual Full Time Replacement~~
~~a. Number of annual issued uniforms to be received by Full Time Security Department Officers will be determined by the Security Manager based on Department needs.~~

~~4. Annual Per Diem Replacements~~
~~a. Number of annual issued uniforms to be received by Per Diem Security Department Officers will be determined by the Security Manager based on Department needs.~~

E. REPLACEMENT OF DAMAGED UNIFORMS:

1. Any replacement of required Security Department uniform items that have sustained work-related damage will be subject to approval and will be replaced in accordance with the ~~U~~uniform ~~P~~procedure to be determined by the Security Manager.

F. NON-COMPLIANCE:

1. Non-Compliance with any portion of this policy may result in disciplinary action leading to, and or including termination.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 08, 1991~~ ~~Reviewed: 4/94, 10/97, 6/03, 11/06, 3/09, 6/11~~ ~~Revision: 07/03~~ ~~Approvals: Director of Security~~	~~Subject: Code Gray – Hostage Response Plan~~ ~~Page 1 of 2~~
~~Submitted By: Tri-City Medical Center~~ ~~Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 505~~

ISSUE DATE: 05/91~~May 08, 1991~~ **SUBJECT: Code Gray – Hostage Response Plan**

REVIEW~~ED~~ DATE~~(S)~~: 04/94, 10/97, 06/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 505**

REVISION DATE~~(S)~~: 07/03,

Department Approval: 05/20
Environmental Health and Safety Committee Approval: 08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. **PURPOSE:**
1. To assure the proper implementation of a first response Medical Center procedure that will result in the successful resolution of any hostage situation that may emerge.
2. To outline a protocol that will prepare each involved individual to maintain discipline, determination, and the proper utilization of sound judgment under stressful conditions.

B. **POLICY:**
1. While each and every hostage incident will vary in both complexity and locality within the Medical Center, to assist all involved personnel, the following guidelines should always be considered:
   a. **Contain** the movements of both the hostage and the hostage taker in order to keep the situation from further escalating. This guideline should only be safely attempted unless the incident factors force the utilization of another action.
   b. **Control** the immediate and orderly removal of all patients, visitors, and staff members from the incident area or department if safely possible.
   c. **Communicate** with all involved personnel all the available pertinent facts regarding the hostage incident. Before any action is taken all personnel **must** be properly briefed and continually updated on all available information

C. **PROCEDURE:**
1. Whoever first discovers an apparent hostage incident, should immediately notify the Medical Center PBX/Operator **for** ~~or~~ a **Code Gray,** the incident location, and any other pertinent information, such as the number of hostages, a complete description of the hostage taker(s), and the description of any weapons.

2. The PBX/Operator will immediately notify the Security Department of the **Code Gray** and the location of the incident.
3. It will be the responsibility of the Lead Security Officer or Senior Officer to respond to the incident location and assume the primary Officer designation. This Officer will remain in this capacity until such time that the Security Supervisor or Designee relieves the Officer.
4. The primary Security Officer will ensure that the Oceanside Police Department and the Security Supervisor or Designee is immediately notified and informed of the incident. The Officer will also be responsible for insuring that he/she or the PBX/Operator initiates the following call-out process.
   a. The ~~Director of~~ Security **Manager**.
   b. The on-duty Administrator / Administrative Coordinator. ~~The on-call~~
   c. The on-call Administrator if after hours.
   d. The Director of Public Relations.
5. Security Department personnel will proceed to the incident location and orderly remove all patients, visitors, and staff members to a safe location and properly secure all approaches into and exits out of the area. Durring the evacuation processes any witnesses will be interviewed regarding pertinent information regarding the incident.
6. A secure area will be established for use as a command center and central location for the hostage negotiation team. A floor plan of the incident area will be obtained from the Engineering Department and a secured communications system will be established.
7. The Administrator or Designee will obtain any pertinent information from the unit Manager or Designee of the affected area or department, regarding the hostage and hostage taker, and reassign needed additional personnel to this area in order to ensure proper staffing and continuance of the necessary medical services.
8. At no time during the hostage situation will any Medical Center personnel attempt to rescue a hostage or disarm a hostage taker. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any Medical Center personnel offer any promises or concessions to the hostage taker.
9. It will be the responsibility of the primary Security Officer to assign the chronological documentation of all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.
10. Upon the arrival of the law enforcement personnel, the Security Department will be responsible to supply any requested support or additional personnel.
11. At the completion of the incident all involved personnel will remain available for interviewing by local law enforcement personnel and will only secure after first receiving authorization to do so from the Security Supervisor or Designee.

D. **PROCEDURE:**

1. Reference Administrative Policy ~~#283~~: Code Gray – Hostage Response Plan **238**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 11, 1991~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 03/09, 5/13~~ ~~Revision: 7/03, 6/11~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Communications~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM – # 205~~

ISSUE DATE: 06/91~~June 11, 1991~~ **SUBJECT:** ~~Security~~ Department Communications

REVIEW DATE: 04/94, 10/97, 05/03, 11/06, 03/09, 05/13 **POLICY NUMBER: 205**

REVISION DATE: 07/03, 06/11

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

A. **PURPOSE:**
1. To establish a standardized procedure for Security Department communications.

B. **POLICY:**
1. The Security Department will establish a standardized format for the departmental communications system and it will be the responsibility of all Security Officers to properly utilize this format.

C. **PROCEDURE:**
1. Currently the Security Department has ~~four~~ **3** types of electronic communication devices available for Security Department communication needs.
   a. Two-Way Radio System
   b. ~~Nextel~~ Cellular**phone** ~~and Two-Way Communications~~
   c. E-mail ~~Application~~
2. The Security Department Two-Way Radio System consists of a ~~R~~repeater~~,~~ and Two-Way Portable Radio with 7 programmed channels. Currently the channels are programmed as follows.
   a. Channel 1: Security Department, Repeater Capable
   b. Channel 2: Engineering Services, Repeater Capable
   c. Channel 3: Environmental Services, Repeater Capable
   d. Channel 4: Lift Team, Back Up System, Line of Sight

e. Channel 5: Food Services, Repeater Capable
f. Channel 6: Engineering Services, Same Frequency as Channel 2
g. Channel 7: Security Tactical Channel, Line of Sight
h. Channel 8: Un-Programmed
i. Channel 9: Un-Programmed
j. Channel 10: Un-Programmed

3. The Security Department Cellular and Two-Way Nextel communications is utilized for Land Line communications to the Medical Center.
4. The Security Department two-way e-mail system is utilized for inner departmental communications to pass on information within the Security Department.
5. When Operating the Two-Way Portable Radio System each Security Officer will maintain a professional demeanor **as other departments use radios**, using ~~either the military or~~ Law Enforcement phonetic spelling format and approved Law Enforcement Radio Codes to ensure that proper communications are established and received by each Security Officer.

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

1. ~~Attached is a copy of the approved~~ Radio Codes ~~to be utilized by all Security Officers with Two-Way Radio communications.~~

Tri-City Medical Center
Oceanside, California

RADIO CODES

10-1 = receiving poorly

10-2 = receiving well

10-4 = acknowledgment

10-6 = busy

10-7 = end of service

10-8 = beginning of service

10-9 = repeat

10-19 = Security Department Trailer

10-20 = location

10-21 = phone call

10-87 = meet officer at location

10-88 = request for cover officer

10-97 = at location

10-98 = finished last call

CODE 1 = normal response

CODE 2 = A.S.A.P. non-emergency

CODE 3 = emergency

CODE 4 = no further assistance

CODE 5 = visual contact

CODE 6 = verbal contact

CODE 7 = physical contact

CODE 8 = bathroom break

CODE 9 = meal | rest break

CODE RED = fire

CODE PINK = infant emergency

CODE ORANGE = disaster

CODE YELLOW = radiation disaster

CODE GREEN = oxygen emergency

CODE BLUE = adult emergency

CODE GRAY = hostage

CODE SILVER = active shooter

CODE ADAM = infant abduction

DOCTOR STRONG = violent person

75 75 = bomb threat

The Security Department utilizes the law enforcement phonetic alphabet.

A = adam | B = boy | C = Charles

D = david | E = Edward | F = frank

G = george | H = henry | I = ida

J = john | K = king | L = lincoln

M = mary | N = nora | O = ocean

P = paul | Q = queen | R = robert

S = sam | T = tom | U = union

V = victor | W = William | X = xray

Y = yellow | Z = zebra

Tri-City Medical Cen
Oceanside, California

DELETE - There is an administrative policy about this and not a problem for the Security Dept.

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: 04/03/02~~ ~~Reviewed: 5/03, 11/06, 3/09, 6/11~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Computer Usage Policy~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 228~~

SUBJECT: Computer Usage Policy

ISSUE DATE: 04/03/02
REVIEWED DATE(S): 5/03, 11/06, 3/09, 6/11
REVISION DATE(S):

POLICY NUMBER: 228

Department Approval Date(s): ~~07/15~~05/20
Environmental Health and Safety Committee Approval Date(s): ~~08/15~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval Date(s): n/a
Board of Directors Approval Date(s):

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

~~1. To establish a set of guidelines for Security Department Personnel to utilize while using Tri-City Medical Center owned or operated computer equipment.~~

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

~~1. All Security Department Personnel will adhere to the following procedure when utilizing any computer equipment owned or operated by Tri-City Medical Center.~~

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

~~1. In addition to following the guidelines of Administrative Policy and Procedure # 242 and 455, Security Department Personnel will utilize the following guidelines.~~
~~2. Security Department Personnel will only utilize Tri-City Medical Center owned or operated computers or computer equipment for Tri-City Medical Center Security Department related business.~~
~~3. Security Department Personnel will only utilize e-mail applications for communications between fellow Security Department Employees.~~
~~4. Security Department Personnel will NOT utilize any Tri-City Medical Center owned or operated computer, computer equipment, or applications for personal related matters, on or off duty.~~
~~5. Security Department Personnel will NOT send any "all users" e-mails through any e-mail application.~~

6. Security Department Personnel will NOT use any e-mail application to make direct contact outside of the Security Department without prior writer approval from the Security Supervisor, or Medical Center Director over the Security Department.

D. **ATTACHMENTSRELATED DOCUMENTS:**

1. Administrative Policy and Procedure # 242: **Use, Security, and Accuracy of Data**
2. Administrative Policy and Procedure # 455: **Confidentiality**

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 04/91 **SUBJECT: Conflict Resolution**

REVIEW~~ED~~ DATE~~(S)~~: 05/94, 12/96, 06/03, 11/06, 03/09, 06/11~~, 07/15~~ **POLICY NUMBER:** 510
REVISION DATE(S): 06/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To establish guidelines, which Security Officers can utilize in the performance of their duty regarding a conflict resolution

B. **POLICY:**

1. It is the policy of the Security Department to employ a safe, nonviolent management system when confronted with a situation involving the need for a conflict resolution. This system has been designed to offer the Officer and those involved the best possible care, safety, and welfare in a crisis situation. Reference Administrative Policy #463 Work Place Violence

C. **PROCEDURE:**

1. When a Security Officer is confronted with a crisis situation the Officer will always utilize the contact / cover concept before initiating contact.
2. The Contact Officer will approach the individual to within three to four feet and slightly to the side. The Officer will maintain a non-threatening stance with one foot in front of the other.
3. The Officer will attempt to initiate a verbal intervention contact utilizing a calm, understanding approach, and trying to determine the precipitating factors, in an effort to reduce the level of anxiety on the part of the individual. The Officer should avoid any outward display of emotion and should listen and not offer any options or comments during this period.
4. After the individual has explained, the Officer should repeat back the main points and offer any assistance available.
5. If the situation escalates the Officer must advise the individual that a confrontation is not the Officer's objective and attempt to obtain voluntary compliance from the individual.
6. If the individual is not willing to voluntary comply, the Officer will advise the individual of the other actions which may be utilized to neutralize the situation.
7. The Officer will only utilize physical force as a last resort and will only use reasonable force or that force which is necessary to neutralize the situation. Any force utilized should always be the least restrictive method and only as a last resort.
   a. Any force used will be in compliance of Security Department Policy #209 regarding the Use of Force.
8. All Officers will be responsible for their own actions and shall not shift to others the burden or responsibility for their own actions.

D. **RELATED DOCUMENTS:**

1. Administrative Policy ~~#463~~: Workplace Violence **463**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 18, 1991~~ ~~Reviewed: 4/94, 1/97, 5/03, 11/06, 3/09, 6/11, 03/12, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Responsibility and Accountability of Delegated Authority~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 107~~

ISSUE DATE: 04/91~~April 18, 1991~~

SUBJECT: ~~Responsibility and Accountability of~~ **Delegated Authority and Accountability of Subordinates**

REVIEW DATE: 04/94, 01/97, 05/03, 11/06, 03/09, 06/11, 03/12, 5/13

POLICY NUMBER: 107

REVISION DATE: 07/03

Department Approval:	**01/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the **accountability, authority, and** responsibility ~~and authority of delegated authority~~ **delegation through the unity of command**.

B. **POLICY:**

1. It will be the responsibility of the **Security** Officer who has received the delegated authority **/ command** to make decisions and take ~~the~~ **all** necessary action**s** to satisfy the requirements ~~of each assigned job assignment~~ **articulated and / or documented by the person who provided the delegation**. With this authority, each **Security** Officer will assume and accept the responsibility for the use and misuse of this authority.

C. **PROCEDURE:**

1. The **Director / Manager and** ~~Security~~ Supervisor has the ultimate authority **/ command** for providing ~~S~~security to the Medical Center and to ensure the ~~S~~safety, ~~S~~security, and ~~W~~welfare of all Patient, Visitors, and Staff Members and their respective property **/ assets**. The **Director / Manager,** ~~Security~~ Supervisor**, and Lead Security Officer** shall have the right to delegate any portion of the**ir**~~is~~ authority **or commands**, which ~~he/she~~**they** deem~~s~~ necessary, to any of ~~his/her~~ **their** subordinates **[relief-lead security officer and security officers]**.
2. Due to the nature and scope of ~~S~~security ~~P~~protection provided on the Medical Center Campus, the **Director / Manager,** ~~Security~~ Supervisor**,** and Lead Security Officers will have the discretion and authority to delegate responsibilities to subordinates.
3. When authority **or commands** ~~is~~ **are** delegated, it will be the responsibility of the **Director / Manager,** ~~Security~~ Supervisor**,** and Shift Lead Officers to insure that **the** subordinate has the

power to act and the ability to carry out the assignment. **Monitoring of the subordinate will be accomplished by direct [supervision] or indirect [delegation] methods.**

4. Even though the subordinates will be held accountable for their actions, nothing in this policy shall absolve the **Director / Manager,** ~~Security~~ Supervisor**, or Lead Security Officer** from the ultimate responsibility and accountability for the supervision of the subordinate and the use of this authority.

5. **Leadership shall be expected to provide proper direction, coordination, and control of all subordinates by either verbal or documented means and with respect to conduct and final disposition.**

~~4.~~6. **This policy shall also apply to any acting / interim leadership personnel.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 28, 1991~~ ~~Reviewed: 3/94, 12/96, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Department Organization~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM # 101~~

ISSUE DATE: 03/91~~March 28, 1991~~

SUBJECT: Department Organization / Unity of Command

REVIEWED DATE~~(S)~~: 3/94, 12/96, 05/03, 11/06, 03/09, 06/11, 50/13
REVISION DATE~~(S)~~: 12/01, 7/03

POLICY NUMBER: 101

Department Approval:	05/20
Environmental Health & Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

~~1. To provide the Security Department with a clear and readily accessible statement of duties and responsibilities for each organizational level and each job assignment.~~

1. **To establish a clear line of authority in order to promote accountability, efficiency, responsibility, and reduce any confusion.**

B. **POLICY:**

~~1. The duties and responsibilities of each organizational level and of each post assignment with the Security Department shall be clearly stated in writing and shall be available for review by all personnel.~~

1. **The principle of unity of command shall be practiced in all departmental components.**

C. **PROCEDURE:**

~~1. The Security Supervisor or designee shall be responsible to maintain a written statement of the duties and assignment of each job assignment within the Security Department.~~

~~2. Each job assignment description shall be clearly written, appropriately updated as needed and maintained so that they may be reviewed by all department personnel.~~

1. ~~Each Security Officer will be given a copy of each job description during their new hire orientation phase of training. It will be their responsibility to maintain the current updated written statements.~~**The levels / unity of command will be as follows: Director / Manager, Supervisor, Lead, Relief-Lead Security Officer, and then Security Officer.**

2. The security officer will be accountable to all the higher levels of command; the lead and relief-lead will be accountable to the supervisor, and the supervisor will be accountable to the Director / Manager.
3. The supervisor will discipline when needed, provide training, and determine the department's operations based on statistics, requests for assistance, and staffing challenges. The supervisor will report upwards through the unity of command.
4. The lead security officer will coach / counsel security officers with coordination by the supervisor short of discipline. The lead will oversee training and coordinate daily-shift operations. The lead represents the supervisor in case of absence and through delegation of responsibility. The lead reports upward through the unity of command.
5. The relief-lead security officer is chosen by the department's leadership members and acts as an authorized representative when a lead is not on property. The relief-lead may be changed based on performance, seniority, and staffing challenges. The relief-lead reports upward through the unity of command.
~~3.~~6. The security officer will adhere to all Security Department policies and procedures and reports upward through the unity of command.

Tri-City Medical Center
Oceanside, California

SECURITY
PERSONNEL

ISSUE DATE: 06/92

SUBJECT: Departmental Personnel Issues

REVIEW~~ED~~ DATE~~(S)~~: 06/94, 10/97, 05/03, 11/06, 03/09, 06/11~~, 07/15~~

POLICY NUMBER: 307

REVISION DATE~~(S)~~: 0 7/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~09/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To provide a set of guidelines for all Security Department personnel, to assist with the proper procedure for document an issue involving another member of the Security Department.

B. **POLICY:**

1. When an interdepartmental incident occurs involving Security Department personnel, or when an Officer feels that an interdepartmental issue should be brought to the attention of the Security Manager, the following process will be utilized. Reference Administrative Policy #428 Fair Treatment for Non-Management Employees

C. **PROCEDURE:**

1. The reporting Officer will immediately complete an Incident Report or complete a Memo to the Security Manager including but not limited to the following information:
   a. The Date, Time and Day of Week the incident took place.
   b. The names and post assignments of all involved Officers.
   c. A detailed description of all related information, this information may have been observed by the reporting Officer or information reported to the Officer by another source outside the Security Department.
   d. A complete statement by any available witnesses.
2. The completed Incident Report or Memo will be immediately forwarded to the Security Manager or Designee, or if after hours, placed into an interdepartmental envelope and sealed. The envelope will then be placed in the Security Manger's In-Box.
3. The Security Manager or Designee will then investigate the issue if deemed necessary and take the necessary action if any.

D. **RELATED DOCUMENTS:**

1. Administrative Policy #428: Fair Treatment of Non-Management

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

ISSUE DATE: 01/93

SUBJECT: Disaster Plan for the Security Department

REVIWED DATE ~~(S)~~: 04/94, 12/96, 12/01, 05/03, 11/06, 03/09, 06/11~~, 07/15~~ **POLICY NUMBER:** 801
REVISION DATE~~(S)~~: 12/01, 07/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To assure adequate security during a disaster. Proper departmental procedures are to be initiated for the safety of all staff, visitors, and patients at the Medical Center.

B. **PERSONNEL:**

1. Security Manager
2. Security Supervisor
3. Lead/Charge Security Officer(s)
4. Security Officers

C. **PROCEDURE:**

1. In the event of a Disaster Alert Phase, the Security Manager of his/her designee will be notified by Administration and advised of the circumstances. It is the responsibility of the Security Manager or his/her designee to:
   a. Review the Security Department Disaster Plan, and Call Back Protocol.
   b. Verify all disaster supplies and equipment, which are currently stored in the Disaster Storage Shed, north of the Security Department Office.
2. In the event of a Disaster Activation Phase.
   a. The Lead/Charge Security Officer on duty will initiate the department call back process and notify the respective Law Enforcement agencies, which are appropriate.
   b. All Security Department personnel will be instructed to report to the Security Department Office or other location within the Medical Center.
   c. The on-duty Lead/Charge Security Officer will assume the position of Duty Officer in the Command Center (HEICS) until such time as he/she is relieved of duty by the Security Manager or his/her designee.
   d. The on-duty Lead/Charge Security Officer will assign Security Officers to provide traffic control for the Triage area, utilizing the placement of signage and any other additional personnel that are deemed necessary.
   e. A Security Officer with two-way radio capabilities will be assigned to the main southern access into the Medical Center (Vista Way entrance). This Officer will have available appropriate traffic control equipment to include but not limited to emergency road flares, signal light, traffic cones, barricades, and caution tape, in order to ensure an orderly ingress and egress into and out of the Medical Center grounds. If necessary additional personnel from this location will also be assigned to monitor any vehicular activity at the Human Resources Building entrance.

f. One Officer and any needed additional personnel, with two-way radio communications will be assigned to the northern and southern entrances into the Medical Center grounds from Thunder Drive. These Officers will also be in possession of traffic control devices to control the traffic flow at these locations.

g. During this Disaster Activation Phase, no individual will be allowed entry into the Medical Center unless they are in possession of their issued Tri-City Medical Center photo identification badge.

h. As the situation permits any or all access ways may be allowed opened by the authority of Administration.

i. All other assignments will be at the direction of the Security Manager or his/her designee.

D. AUTOMATIC REVIEW:

1. This policy/procedure will be annually reviewed and updated as needed. It is the responsibility of the Security Manager to:
   a. Orient and educate all Security Officers to the Disaster Plan.
   b. Maintain an updated version of the Disaster Plan and Call Back Roster.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 11/90

SUBJECT: Disposal of Drugs and Drug Paraphernalia

REVIEWED ~~DATE(S)~~: 04/94, 11/96, 10/01, 06/03, 11/06, 03/09, 06/11~~, 07/15~~ **POLICY NUMBER:** 506
REVISION DATE~~(S)~~: 07/03, 09/15

Department Approval ~~Date(s)~~: ~~07/15, 10/18~~05/20
Environmental Health and Safety Committee Approval ~~Date(s)~~: ~~08/15, 11/18~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval Date(s): ~~09/15~~ n/a
Board of Directors Approval Date(s): 09/15

A. **PURPOSE:**

1. To set forth the District's procedure for handling and disposing confiscated and/or discovered drugs and/or drug-use paraphernalia.

B. **DEFINITIONS:**

1. Drugs:
   a. Substances recognized as drugs in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or the official National Formulary or any supplement to any of them.
   b. Substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or animal.
   c. Substances (other than food) intended to affect the structure or any function of the body of man or animal.
2. Drug-Use Paraphernalia:
   a. All equipment, products, and materials of any kind which are designed for use or marked for use in planting, propagating, cultivation, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance.

C. **POLICY:**

1. Any District employee who finds or confiscates any drug or drug paraphernalia on District property shall immediately notify the Security Department. Reference Administrative Policy #217 Disposal of Drugs and Drug Paraphernalia.

D. **PROCEDURE:**

1. Upon receiving information of found drugs or drug paraphernalia, the Security Department will immediately dispatch a Security Officer to the location, take possession of such items and establish a chain of custody. The Security Officer will then obtain the necessary information needed to complete the appropriate Security Department report.
2. The collecting Security Officer will then immediately notify the Security Supervisor and / or the Lead Security Officer and the Oceanside Police Department. The officer will request that O.P.D. be sent to retrieve the discovered or confiscated drugs/paraphernalia, or the officer will request disposition instructions from O.P.D. Upon the arrival of the Oceanside Police

Department, the Security Officer will turn over all seized items and inform the Police Officer of all pertinent facts involved with the seizure. The Security Officer will be responsible for obtaining the Police Officer's name, badge number, and the time the items were released.

3. The collecting Security Officer will be responsible for the proper completion of all necessary reports. The Security Officer will further be responsible for noting all facts in his/her Daily Security Report.

E. RELATED DOCUMENTS:

1. Administrative Policy ~~#217~~: Disposal of Drugs and Drug Paraphernalia **217**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 03/94

SUBJECT: Emergency Department Patient Parking

REVIEWED DATE(S): 12/96, 06/03, 11/06, 06/11, 07/15

POLICY NUMBER: 225

REVISION DATE(S): 6/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To ensure that arriving patients seeking medical treatment in the Medical Center's Emergency Department have an unrestricted location for the timely loading and unloading and that there is a lot location which is reserved for long term vehicle parking.

B. **POLICY:**

1. It is the policy of the Security Department that all on-duty Officers will actively enforce an unrestricted area for the timely loading and unloading of patients and long term parking of vehicles for patients in the Emergency Department.

C. **PROCEDURE:**

1. It is vitally important that all arriving patients, seeking medical treatment in the Emergency Department, or Women's Center, be afforded an unrestricted location, adjacent to the main entrances for the timely unloading and or loading.
2. It is the primary responsibility of the Security Officer assigned to the Emergency Department to actively patrol and enforce, as needed this area. In addition, if circumstances warrant, other on-duty Security Officers will be requested to assist with this area.
3. Upon contacted a legally parked vehicle, the Security Officer will note that time and after a reasonable designated time have PBX page the owner and request the moving of the vehicle. This vehicle will be monitored until such time that it is moved.
4. The Security Officer paging any parked vehicle will complete an appropriate Daily Security Report entry for each paging occurrence.
5. Any vehicle, is either parked in such a matter as to create a serious traffic hazard or whose occupants aren't seeking medical treatment, will be IMMEDIATELY paged through PBX as described in Section 3.3 of this policy.
6. At no time will any Security Officer offer statements that could be perceived as a threat to tow any owner's parked vehicle unless it is creating an extreme traffic hazard or the occupants aren't seeking medical treatment.
7. Before any vehicle is physically removed from the Medical Center campus the initiating Security Officer will first notify the Security Supervisor or Designee.

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

ISSUE DATE: 04/03 **SUBJECT: Emergency Situation Officer Recall**

REVIEWED DATE(S): 12/96, 05/03, 11/06, 03/09, 06/11, ~~07/15~~ **POLICY NUMBER: 803**
REVISION DATE(S): 07/03, 07/10, 10/10, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To establish guidelines to be utilized in the event of an Emergency Situation or Disaster Alert, or for the immediate recall of additional Security Department personnel due to Emergency or staffing need.

B. **POLICY:**

1. All Medical Center Security Officers are required to maintain in good working order a telephone or telephone message system that allows for contact within 2 hours, in the event of an emergency or Security Department need.

C. **PROCEDURE:**

1. In the event of an emergency situation or Department need requiring the recall of additional Security Department personnel during off hours, the Shift Lead Officer or Designee will use the chain of command to notify the Security Supervisor prior to activating the Officer Recall chart.
2. The Security Shift Lead Officer or Designee will go down the list calling each Officer starting with the Officers on the shift needing to be filled first, followed by other shift Officers as needed and recording the results of each call. If necessary the Security Supervisor, Designee, or Shift Lead Officer will appoint another Security Officer or Medical Center Employee call each Officer.
3. Each Officer called will be informed of the need for additional Security Department personnel, and that he is being recalled. The Officer will be briefed on his duties for the situation or Emergency when he arrives on post.
4. Each Officer called is required to respond or return the phone call no later than 2 hours from the time the message was left and documented.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE:	**04/91~~April 16, 1991~~**	**SUBJECT:**	**Exterior Campus Rounding**
REVIEW~~ED~~ DATE(~~S~~):	**06/94, 01/97, 05/03, 11/06, 03/09, 06/11**	**POLICY NUMBER:**	**227**
REVISION DATE(~~S~~):	**07/03, 03/09, 06/11, 12/15**		

Department Approval:	**~~08/15~~05/20**
Environmental Health and Safety Committee Approval:	**~~09/15~~08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~11/15~~ n/a**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**

1. To establish a procedure for exterior rounding of the campus and follow-up actions to take if there are findings..

B. **POLICY:**

1. It is the responsibility of all Security Officers to monitor and document any condition, at the Medical Center, which would be considered unsafe to any Patient, Visitor, Medical Staff or Employees.
2. While conducting exterior rounding the patrolling officer will notate any of the following:
   a. Uneven walking surfaces or tripping hazards
   b. Any exterior lighting that is out
   c. Any down foliage or landscaping needs that may be a safety hazard
   d. Evidence of vandalism or break-ins
   e. Damaged or malfunctioning door locks
   f. Patient or visitor assistance
   g. Suspicious activity
   h. Potential medical emergencies

C. **PROCEDURE:**

1. For any medical emergencies, the Security Officer shall contact the PBX operator for either a rapid response team or Code Blue/Pink as indicated.
2. For non-urgent medical the Security Officer shall contact the Emergency Department Charge Nurse for direction or assistance.
3. Upon observing or detecting any unsafe condition(s), the Security Officer shall complete a work order on the TAMIS work order system through the intranet.
4. If the unsafe condition is of an extreme nature, the Security Officer will immediately notify the Safety Officer or on-duty engineer of the condition.
5. Place a printed copy of the work order page in the binder for Work Orders. Notate the work order on the item list.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 04/94

SUBJECT: Exterior Doors Locking / Unlocking Schedule ~~Security~~

REVIEW~~ED~~ DATE~~(S)~~: 06/00, 03/01, 06/03, 11/06, 03/09, 06/11, 07/15

POLICY NUMBER: 222

REVISION DATE~~(S)~~: 02/97, 03/01, 07/03, 09/15, 05/2020

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. As part of the security program at the Medical Center, the locking and unlocking of all doors will be accomplished by the appropriate **and**~~,~~ designated on-duty Security Officer in accordance with the following policy.

B. **POLICY:**

1. It is the policy of the Security Department to ensure that the proper procedure of locking and unlocking of exterior doors is completed in a timely and efficient manner.

C. **PROCEDURE:**

1. The Security Officer assigned ~~to the following post~~ will be responsible for ensuring that the following door locations are **locked** at the appropriate time frame and day of the week:
   a. ~~**E-1 SECURITY POST – Evening Shift at 1700 - 2200**~~
      ~~i. Business and Management Services, west side door, (Monday – Sunday) 20:30 hours.~~
      i. Business and Management Services Building [Monday – Sunday] by 20:30 hours
      ~~ii. Ancillary, northwest door, (Monday – Sunday) 20:30 hours.~~
      ~~iii.~~**ii.** Women's Center~~,~~ (Monday – Sunday) **by** 20:30 hours.
      ~~iv. Ancillary, northeast door to lower level, (Monday – Sunday) 20:30 hours.~~
      ~~v. South Tower, south side lower level door, (Monday – Sunday) 20:30 hours.~~
      ~~vi. Business and Management Services, east side door, (Monday – Friday) 20:30 hours.~~
      ~~vii.~~**iii.** French Rooms~~,~~ **and Hallway access point [by B.H.U.]** (Monday – Sunday) **by** 20:30 hours.
      ~~viii.~~**iv.** Shipping and Receiving~~,~~ both sets double doors~~,~~ (Monday – Sunday) **by** 17:00 hours. **Also turn on the exterior loading dock lights**
   ~~b. **E-2 SECURITY POST 1700 – 2200**~~
      ~~i.~~**v.** Administration~~,~~ all interior and exterior doors~~,~~ (Monday – Friday) **by** ~~17:00~~ **20:30** hours
      ~~ii.~~**vi.** 2095 Vista Way/Location #T~~,~~ (Monday – Friday) **by** 21:00 hours.
      ~~iii.~~**vii.** Main Lobby (Monday – Friday) **by** 20:30 hours.
      ~~iv. Outpatient Discharge door, (Monday – Sunday) 20:30 hours.~~

~~v.~~**viii.** Imaging Department reception area~~,~~ both east side and west side doors~~,~~ (Monday – Sunday) **by** 20:30 hours.

~~c. G-2 SECURITY POST 2200~~

~~i.~~**ix.** Pavilion basement east side stairwell doors~~,~~ (Monday – Sunday) **by** 2~~2~~0:~~0~~30 hours.

~~ii.~~**x.** All Pavilion classroom and assembly room doors~~,~~ (Monday – Sunday) **by** 2~~2~~0:~~0~~30 hours.

~~iii. Outpatient discharge door, (Monday – Sunday) 22:00~~

2. The Security Officer assigned ~~to the designated post~~ will be responsibly for ensuring that following door locations are **unlocked** at the appropriate time frame and day of the week:

a. ~~G-1 SECURITY POST~~**Night Shift by~~–~~ 0430**

i. Business and Management Services~~, west side door,~~ **Building** (Monday – Friday) **by** 0~~5~~4:43~~0~~ hours.

~~ii. Ancillary, northwest door, (Monday – Sunday) 04:30 hours.~~

~~iii.~~**ii.** Women's Center, (Monday – Sunday) 04:30 hours.

~~iv. Ancillary, northeast door to lower level, (Monday – Sunday) 04:30 hours.~~

~~v. South Tower, south side lower level door, (Monday – Friday) 04:30 hours.~~

~~vi. Business and Management Services, east side door, (Monday – Friday) 04:30 hours.~~

~~vii.~~**iii.** French Rooms~~,~~ **and Hallway [by B.H.U.]** (Monday – Sunday) **by** 04:30 hours.

~~b. G-2 SECURITY POST – 0430~~

~~i. Administration, all interior and exterior doors, (Monday – Sunday) 04:30 hours.~~

~~ii.~~**iv.** Main Lobby (Monday – Friday) **by** 04:30 hours.

~~iii. Outpatient Discharge door, (Monday – Sunday) 04:30 hours.~~

~~iv.~~**v.** Imaging Department reception area~~,~~ both east side and west side doors~~,~~ (Monday – Sunday) **by** 04:30 hours.

~~c. D-1 SECURITY POST – 0700~~

~~i. Behavioral Health Unit (Monday – Sunday) 07:00 hours.~~

~~d.~~**b.** ~~D-2 SECURITY POST~~**Day Shift by~~–~~ 0700**

i. 2095 Vista Way/Location #T~~,~~ (Monday – Friday) **by** 07:00 hours.

3. Doors to Administration will remain locked on Saturday, Sunday and all holidays.
4. Doors to the Business and Management Services building will remain locked on Saturday, Sunday and holidays, unless payroll processing is being completed. Each shift**'s** officers will be responsible for adjusting his/her unlocking schedule to accommodate this process.
5. It will be the responsibility of the Security Supervisor/designee to inform all Security Officers, in writing, of any exceptions to this procedure.
6. Doors will not be propped open or otherwise manipulated to prevent locking. Doors left unlocked for any reason will constitute a breach of security. All doors found in this condition will be immediately secured and the officer will proper document his/her actions (including door location and number) on their Daily Security Report (DSR).
7. Any staff/physician request for after hour access to any locked location will be conducted in accordance with current Security Department policy.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 04, 1991~~ ~~Reviewed: 4/94, 12/96, 6/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Fleeing Medical Center Patients (Patient Elopement/AMA Patient)~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM # 213~~

ISSUE DATE: **04/91~~April 04, 1991~~** **SUBJECT:** **Fleeing Medical Center Patients (Patient Elopement/AMA Patient)**

REVIEWED DATE(~~S~~): 04/94, 12/96, 06/03, 11/06, POLICY NUMBER: 213
03/09, 06/11, 05/13
REVISION DATE(~~S~~): 07/03, ~~5/2020~~

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the policies, procedures, and responsibilities governing the apprehension of a fleeing Medical Center Patient.

B. **POLICY:**
1. In the event that a Security Officer either observes or is notified of a patient attempting to flee from either medical supervision or treatment, the below listed procedure will be immediately implemented.

C. **PROCEDURE:**
1. When a Security Officer observes a patient attempting to flee from a medical unit, the Officer will immediately determine if the ~~P~~patient is on a ~~P~~psychiatric or ~~M~~medical hold and notify all other ~~S~~shift ~~O~~officers of the location and need for assistance via the radio.
2. **If the patient is not on a psychiatric or medical hold, the officer will safely attempt to make verbal contact with the patient while on T.C.M.C. property and convince them to return. If the patient is uncooperative, the security officer will not pursue them off of property.**
3. **If the officer is told or observes medical equipment [e.g. cardiac monitor or intravenous line] on the patient's body or possessed by the patient, the officer will make an effort to convince the patient to surrender the T.C.M.C. property while abiding by Non-Violent Crisis Intervention [N.V.C.I.] verbal de-escalation techniques.**
4. **The security officer will notify the patient's floor and request additional assistance with the patient by asking for a medical staff member; if the patient leaves, the security officer will not pursue the patient and will notify the floor and provide an update.**

5. **If the Patient is on a psychiatric or medical Hold, an immediate pursuit will be implemented while the patient is known to be on T.C.M.C. property.**

~~2. If the Patient is on a Psychiatric or Medical Hold, an immediate pursuit will be implemented~~

~~3.~~6. When the Officer(s) **verbally** contacts the patient, verbal intervention will be utilized~~,~~ unless the patient is displaying violent or combative behavior or on a ~~P~~**p**sychiatric or ~~M~~**m**edical ~~H~~**h**old. Any use of force on **the** part of the ~~S~~**s**ecurity ~~O~~**o**fficer will always be reasonable and only that force which is necessary to ~~subdue~~**keep** the patient **on property** if the patient is on a ~~P~~**p**sychiatric or ~~M~~**m**edical ~~H~~**h**old. At all times the Officer will utilize intervention techniques, which focus on the best possible care and welfare of the patient **and in coordination with N.V.C.I. physical applications**~~.~~

a. Any **physical** -force used will follow the guidelines of Security Department Policy #209 regarding the Use of Force.

b. **At no time will any security officer utilize bodily-slams, limb manipulation or pressure-point applications, restriction of airway / asphyxiation, or any type of choke-hold maneuvers in order to keep the patient from eloping.**

~~a.~~c. **Examples of physical force options consist of the following but are not limited to: verbal contact and intervention [first], situational proximity i.e. standing in the way/ using your body as a deterrent [second], and then physical strength / N.V.C.I. application techniques [last].**

~~4.~~7. The same procedure will be implemented when the ~~S~~**s**ecurity ~~O~~**o**fficer is notified by either the portable radio or a member of the medical staff. If a considerable amount of time has passed since the patient has been seen, the ~~O~~**o**fficer will immediately implement the Missing Person Procedure as per Administrative Policy #305.

8. At no time will a ~~S~~**s**ecurity ~~O~~**o**fficer pursue a fleeing patient off the Medical Center property. If a patient has fled the campus, the ~~S~~**s**ecurity ~~O~~**o**fficer will immediately notify the appropriate Unit Supervisor/Charge Nurse and contact the local ~~L~~**l**aw ~~E~~**e**nforcement agency and advise them of the incident and last seen location and direction of travel.

~~5.~~9. **Any / all excessive use of force while pursuing a fleeing patient will incur discipline up to termination.**

Tri-City Medical Center
Oceanside, California

SECURITY PERSONNEL

ISSUE DATE: 04/91

SUBJECT: Hair and Grooming Standards for Security Officers

REVIEWED DATE(S): 06/94, 12/96, 03/02, 05/03, 11/06, 03/09, 06/11
REVISION DATE(S): 03/02, 07/03, 09/15

POLICY NUMBER: 302

Department Approval:	07/15 05/20
Environmental Health and Safety Committee Approval:	08/15 08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	09/15 n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. The Medical Center has a right to expect Security Department Oofficers to present a neat, clean, and well-groomed appearance, whether in **a Tri-City provided** uniform or civilian **personal** attire. Both hairstyle and civilian **personal** dress style are recognized as an individual matter,; however, when an Oofficer interacts on or off duty, they will follow the below criteria.

B. **POLICY:**

1. All Security Officers, whether on or off duty will conform to the hair and grooming guidelines while they are on **duty and on** the Medical Center Campus.

C. **PROCEDURE:**

1. Regardless of style, the Oofficer's hair shall not in any way interfere with proper and efficient performance of their duties.
2. Male Grooming Standards:
   a. Front and side hair length: Hair may be worn at any length on the front and sides as long as it can't be extended into eyes and interfere with the Oofficer's vision.
   b. Back: Hhair may be worn at any length and style as long as it doesn't extend below the top of the shirt collar.
   c. Hair shall be kept neat, clean, and well groomed at all times.
   d. Sideburns shall be trimmed so that they don't extend below the mid-ear. The bottom portion of the sideburn will be trimmed and at no time wider than one inch in width.
   e. Facial hair in the form of a mustache is permitted, but will be kept neat, clean, and well trimmed at all times. The mustache will not exceed lower than one-quarter inch past the smile crease line.
   f. Beards **and goatees** are not permitted at any time **with a medical note and per approval of the Manager or Supervisor**.
3. Female Grooming Standards.
   a. Hair shall be kept in a neat, clean and well-groomed manner and will either be cut in length or worn in a style, which doesn't extend below the top of the collar. The length or style also pertains to the hair extending in the Oofficer's eyes in such a manner as to interfere with their vision.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: October 27, 1994~~ ~~Reviewed: 12/96, 1/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Hazardous Materials~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 513~~

ISSUE DATE: 10/94~~October 27, 1994~~ **SUBJECT: Hazardous Materials**

REVIEW~~ED~~ DATE~~(S)~~: 12/96, 01/97, 05/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 513**

REVISION DATE~~(S)~~: 07/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide information and guidelines for all Security Department personnel regarding Hazardous Materials which are upon the Medical Center campus.

B. **POLICY:**
1. It is the policy of the Security Department that anytime an Officer learns of an alleged hazardous materials spill the Officer will utilize the following procedures.

C. **PROCEDURE:**
1. In the event of an alleged Hazardous Materials spill or release, ~~a~~ Security Officers will utilize the following procedure.
   a. It is the responsibility of the first Security Officer on scene of the alleged Hazardous Materials spill or release, to assume and maintain the position of Primary Officer until such time that they are relieved by the Security Supervisor, Shift Lead Officer, or Medical Center Safety Officer
   b. Approach Cautiously – Resist the urge to rush in, you cannot help others until you know what you are facing.
   c. Identify the Hazards – Attempt to determine the identity of the Material in question and quantity of the spill or release. Interview all knowledgeable persons on the scene for any pertinent information. Evaluate all available identifying place cards, symbols, container labels, and shipping papers.
   d. Secure the Scene – Without entering the immediate hazard area, do what you can to isolate and secure the area and assure the Safety, Security and Welfare of all

Patients, Visitors, and Staff Members. Move and keep all Patients and Visitors away from the immediate area.

e. Notification – The Primary Officer will ensure that the following key personnel are immediately notified of the potential Hazardous Materials spill or release.
   i. Medical Center Safety Officer
   ii. Security Supervisor
      1) The Security Supervisor will be responsible for notifying the ~~Director over the Security Department if necessary~~ **Security Manager**.
   iii. Administration or Administrative Coordinator on duty.
   iv. On-Duty Engineer

f. If appropriate, assist as needed with any specialized Hazardous Materials Team.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 03, 1991~~ ~~Reviewed: 5/94, 12/96, 9/99, 6/03, 11/06, 3/09, 6/11~~ ~~Revision: 6/99, 6/03~~ ~~Approvals: Director of Security~~	~~Subject: Impounding of Dangerous Weapons on Medical Center Campus~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 508~~

ISSUE DATE: **04/91~~April 03, 1991~~** **SUBJECT: Impounding of Dangerous Weapons on Medical Center Campus**

REVIEW~~ED~~ DATE~~(S)~~: 05/94, 12/96, 09/99, 06/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 508**
REVISION DATE(S): 06/99, 06/03

Department Approval: 05/20
Environmental Health and Safety Committee Approval: 08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. **PURPOSE:**
1. To provide guidelines for all Security Department personnel, for insuring that patients and visitors are not permitted to bring weapons upon the Medical Center campus.

B. **POLICY:**
1. It is the primary objective of the Security Department to provide a safe and secure environment for all Patients, Visitors, and Staff Members and free of any weapons, which could cause bodily harm or injury.

C. **PROCEDURE:**
1. Whenever a Security Officer discovers or is notified by staff of the presence or a weapon in the position of a Patient or Visitor, the Security Officer will immediately respond to the location of occurrence.
2. After evaluating the circumstances of the situation, the responding Security Officer, utilizing the following options, will determine the most practical and safe way to secure the weapon.
   a. If upon admission a patient brings a weapon into the Medical Center, the weapon will be confiscated and released to a responsible family member **if legally possessed.**
   b. If a family member is not present, the weapon will be confiscated, made safe, placed in a proper container and locked in the Emergency Department Security Office (EDSO) for safekeeping. A "Property Custody" form will be completed with the receipt given to the patient and the department copy attached to the item.
   c. If the patient is already in a patient care area, the Security Officer will confiscate the weapon and follow section 3.2.1 or 3.2.2 in a timely manner.
   d. If it is determined that a Visitor had entered the Medical Center in possession of a weapon, the Security Officer will make contact and inform the visitor of this policy. The

visitor will then be directed to immediately remove the weapon from the Medical Center campus or turn the weapon over to the Security Department for safekeeping. If the weapon is given to the Security Department for safekeeping a "Property Custody" form will be completed.

e. If a Patient or Visitor is unwilling to secure the weapon, the Security Supervisor/Shift Lead will be informed of the situation and attempt to gain cooperation with the individual **if unsuccessful the Lead/Supervisor will contact the Oceanside Police Department for Assistance**.

f. If a Patient or Visitor is displaying the weapon in a reckless manner, causing a disturbance, or problem, threatening to cause a problem or disturbance, or is placing unusual/unreasonable demands on the staff, the responding Security Officer will only attempt contact if the safety and security of all involved parties will not be placed in jeopardy.

g. If the situation has escalated to the point where there is a high probability of harm or injury occurring, the responding Security Officer will immediately ensure that the Oceanside Police Department is contacted for assistance. The Security Officer will also ensure that an attempt is made to remove all persons from the immediate location safely.

h. **If it is learned that a weapon is present on the Medical Center Campus in a Patient or Visitor's belongings or vehicle, a complete check of these items will be conducted. If a weapon is found it will be made safe and secured until such time that the Oceanside Police Department can be contacted to recover the weapon. If Security is unable to gain access to the belongings the Oceanside Police Department will be contacted for assistance.**

3. At **NO TIME** will any Security Officer attempt any actions, which could have an adverse affect on the Safety, Security, and Welfare or any Patient, Visitor, or Staff Member.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

ISSUE DATE: 05/03

SUBJECT: ~~Security Department~~ Key Rings and Security Department Key Control

REVIEWED DATE(S): 07/15
REVISION DATE(S): 09/15

POLICY NUMBER: 406

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To establish a set of guidelines for Security Department personnel to utilize in the performance of their assigned duties related to Key Control.

B. **POLICY:**

1. It is the Policy of the Security Department to maintain a department set of keys that are not to be removed from the Medical Center campus.

C. **PROCEDURE:**

1. The Security Department Supervisor will be responsible for maintaining a predetermined number of sets of Medical Center key rings **[6]** for use by Security Department personnel.
   ~~a. One Master Key set will be maintained for the 1-Post Position.~~
   ~~b. One Master Key set will be maintained for the 2-Post Position.~~
   ~~c. One Master Key Set will be maintained for the 3-Post Position.~~
   ~~d. One Master Key Set will be maintained for the 4-Post Position.~~
   ~~e. At least 2 sets of Cart Keys will be maintained within the Security Department.~~
   ~~f. One Shred-PHI Bin key will be maintained within the Security Department.~~
   ~~g. One Card Access Key will be maintained within the Security Department for access into the Business and Management Services building.~~
2. **When on-duty, all security officers will be given a set of keys, and it is the responsibility of that officer accepting the keys to return the keys at the end of shift.**
~~2.~~**3.** At no time will any Security Department personnel for any reason remove any Security Department maintained sets of keys from the Medical Center without prior approval from the Security Supervisor or Designee**; any non-adherence to this policy will lead to discipline up to termination.**~~.~~

Tri-City Medical Center
Oceanside, California

SECURITY
QUALITY ASSURANCE AND RISK MANAGEMENT

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 15, 1994~~ ~~Reviewed: 1/01, 12/01, 6/03, 11/06, 3/09, 6/11~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Litigation Documents~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 701~~

ISSUE DATE: 04/15~~April 15, 1994~~ **SUBJECT: Litigation Documents**

REVIEW~~ED~~ DATE~~(S)~~: 01/01, 12/01, 06/03, 11/06, 03/09, 06/11 **POLICY NUMBER:** 701
REVISION DATE~~(S)~~: 12/01, 07/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Due to the sensitive and service orientated nature of the Tri-City Medical Center's business, there are occasions when litigation arises in regards to various types of liability. These include medical malpractice, the exercise of professional judgement, the request of medical record information, and general liability issues such as public safety.

B. **POLICY:**

1. It is the policy of the Security Department that any individual(s) attempting to serve any and all legal documents, involving the Medical Center, be directed to the properly designated Medical Center personnel in the most expeditious manner available.

C. **PROCEDURE:**

1. When any Security Officer becomes aware of any individual(s) attempting to serve any legal document~~s~~, upon the Medical Center campus, he/she will immediately **verbally** contact ~~and remain with~~ the subject ~~until completion of this service~~ **and ascertain where the documents need to go and which department needs to be informed**.
2. All legal documents addressing litigation involving the Medical Center will be directed to the ~~office of the Chief Executive Officer~~ **the hospital Legal Department [follow their chain of command]**.
3. All legal documents requesting medical record information will be directed to the Medical Records Department.
4. Any labor/employee related document will be referred to the Human Resources Department for proper processing.
5. At no time will any Security Officer personally accept any legal document from any individual attempting service.

6. Any individual attempting document service, after normal business hours or on the weekends, should be directed to return to the appropriate location of service during regular business hours.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 08, 2000~~ ~~Reviewed: 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Locker Entry by Force~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 206~~

ISSUE DATE: **September 08, 2000** **SUBJECT:** **Locker Entry by Force**

REVIEW~~ED~~ DATE~~(S)~~: **05/03, 11/06, 03/09, 06/11, 05/13** **POLICY NUMBER: 206**

REVISION DATE~~(S)~~: **07/03~~, 5/2020~~**

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department to utilize when requested to force entry into a locker.

B. **POLICY:**
1. The Security Department has the authority for authorizing forced entry into secured lockers inside the Medical Center.

C. **PROCEDURE:**
1. The Security Department, in conjunction with the appropriate~~,~~ / immediate supervisor/designee may authorize forced~~-~~entry into a locker when requested by the person assigned **to** the locker has exhausted all alternatives to opening said locker.
2. Forced entries of lockers are accomplish**ed** only after security is satisfied that the party requesting actually uses the locker and all other means of access have failed.
3. At this time, the Security Department will **first** use **the bolt-cutters to gain entry but is authorized by** whatever means necessary or available to gain access to the locker~~,~~ keeping damage to a minimum.
4. Once said locker has been entered, the removal and securing of any property will be the responsibility of the requesting party and his/her immediate supervisor/designee.
   a. If requested, the Security Department will assist in the inventory of any locker contents when forced~~-~~entry is being made to a locker considered abandoned and while acting under the direction of the department supervisor/designee. **In addition, a Human Resources Department representative must have been scheduled / present if an abandoned locker is to be forced-open.**

b. It will be the responsibility of the department supervisor/designee to ensure that the locker contents are returned to the proper owner **if known, and it will be the responsibility of the H.R. representative to ensure that the locker's contents are confiscated by H.R.**~~.~~

5. At no time will Security access a locker without the physical presence of the department supervisor/designee and the employee or medical staff member requesting the access.
6. The Security Department and a representative from Administration may enter a locker by force if it is deemed necessary for hospital safety.
   a. It will be the responsibility of the Security Officer involved in a forced locker entry to properly document~~,~~ in details~~,~~ all pertinent facts associated with this detail on his/her Daily Security Report and if appropriate on a department Incident Report.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 05/03

SUBJECT: Lost and Found Procedures for Security Department

REVIEWED DATE(S): 11/06, 03/09, 07/15
REVISION DATE(S): 04/08,0 6/11, 09/15

POLICY NUMBER: 230

Department Approval:	07/15
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To establish guidelines for Security Department personnel to utilize when receiving Lost and Found items.

B. **POLICY:**

1. It is the policy of the Security Department to utilize the following procedure when receiving, returning, and disposing of Lost and Found articles.

C. **PROCEDURE:**

1. Receiving Lost and Found Items
   a. When Security is requested to receive a Lost and Found item, the responding Security Officer will inquire as to the owner's name, phone number, and call them as to ensure that every attempt has been made to identify and return the item to the owner. If this information is collected late at night, the shift will still collect the contact information, and ask the following shift to place the call. If after every reasonable attempt has been made, it is the responding Officer's responsibility to properly log in the item(s) to the Lost and Found Logbook #2.
   b. A Lost and Found Property Slip will be completed with a detailed description of the item(s) contents. The responding Officer's information must be included in the "Received by" area as well as the item number documented on the Property Slip, owner's name, and owner's phone number.
   c. All applicable information will be logged into the **Lost and Found Logbook #2**. The Property Slip needs to be placed inside the belongings bag, and the item number labeled with label facing toward the front on the outside of the bag with the bag tied in a knot so the belongings do not fall out when moved.
   d. All Lost and Found items will be logged into the Lost and Found Logbook before being sent to their area for storage (i.e. Pharmacy, Safe, Customer Relations). Valuables such as jewelry, money, checks, credit cards etc. will be collected when a second officer is available as a witness. Valuables will be locked in the small (Drop) safe located inside the Lost and Found office and Logged in the **Lost and Found Valuables Property Logbook #5**. The item(s) will be placed in a white Valuables envelope with article description, date inserted, and officer's signature printed on a valuables inventory sheet and placed on the outside of the envelope. Driver's License, ID cards, health cards, and paperwork will be placed in the locked metal cabinet as well as bulk items of value (i.e. laptops, cell phones, and other electronic devices).

Prescription eyeglasses and Patient Care items (i.e. hearing aides, medic alert devices, dentures etc.) are to go to the Customer Relations office located next to the Main Admitting Department waiting room.

2. Lost and Found Inquiries
   a. The Responding Security Officer will complete a detailed search for the lost item(s). If the item is not located, the individual's name, phone number, date of inquiry and description of the lost item(s) need to be taken and logged into the **Lost and Found Inquiry Logbook #3**.
3. Returning Lost and Found items.
   a. When requested to return an item, every attempt will be made to ensure that the item is being returned to the proper owner.
   b. The Officer will have the owner or person receiving the property complete the Lost and Found Property slip by signing for the item.
   c. The Officer will then complete the Lost and Found disposition section of the Lost and Found Log and file the Property slip in the Property Slip Bin.
   d. When returning lost and found valuables, the Officer must verify that the person claiming the item is the owner, and positive ID made through photo identification. If the person claiming the item is someone other than the owner, they must show proof of Durable Power of Attorney for the owner or a letter from the owner approved by the Customer Service Representative.
4. Destruction of Lost and Found Property
   a. If any Lost and Found items are not returned within 90 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.
   b. Any soiled articles, flammable items (i.e. lighters, matches, flammable liquids or items containing flammable liquids), or perishable items such as food will be logged into the Lost and Found Log Book then disposed of and notated in the disposition area with the reason for disposal.

D. **RELATED DOCUMENTS:**

1. Administrative Policy ~~#202~~: Lost and Found Articles **#202**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 01/94

SUBJECT: Media Relations

POLICY NUMBER: 229

REVIEWED DATE(S): 01/96, 01/97, 05/03, 11/06, 03/09, 06/11, ~~07/15~~
REVISION DATE(S): 7/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. PURPOSE:

1. To establish a systematic process for Medical Center Security Officers to utilize when interacting with members of the Media upon the Medical Center campus.

B. POLICY:

1. It is the policy of the Security Department to cooperate with all members of the Media whenever possible. In an effort to facilitate this process the following procedure will be followed. Reference Administrative Policy #372 Consent to Photograph/Videotape and Policy #524 Disclosure of Information to Public and Media

C. PROCEDURE:

1. Only the Chief Marketing Officer (CMO), Director of Marketing, Chief Executive Officer, or the CEO's Designee shall release any information or statements on behalf of the President and Chief Executive Officer or the Medical Center to members of the Media pertaining to any and all incidents that might occur in or on the Tri-City Medical Center campus and offsite locations.
2. When any Security Officer becomes aware that a member of the Media is on the Medical Center campus or receives a request of any type or is approached by any member of the Media, the Officer will immediately forward such requests to the CMO by calling direct, paging, or going through the operator. Once contact has been established with the Public Relations representative the Security Officer will escort and wait with the Media representative until such time that they are met by the Public Relations representative at a designated location.
3. At no time will any member of the Media be allowed to obtain any type of information verbal or written, or gain entry into the Medical Center without prior approval from the CMO, Director of Marketing or Designee.
4. If a Security Officer is unable to positively establish that a member of the Media has received proper authorization to be at the Medical Center, the Officer will politely ask the member of the Media to immediately leave the Medical Center campus.
5. At no time will any Security Officer seize or impound any photographic or reproductive equipment, film or written correspondence from any member of the Media.

D. RELATED DOCUMENTS:

1. Administrative Policy ~~#372~~: :Consent of Photography/Videotape **372**
2. Administrative Policy ~~#524~~:: Disclosure of Information to Public and Media **524**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2003~~ ~~Reviewed: May 05, 2003~~ ~~Revision: 10/11~~ ~~Approvals: Director of Security~~	~~Subject: Medical Center Off-Site Locations~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 204~~

ISSUE DATE: **05/03~~May 05, 2003~~** **SUBJECT: Medical Center Off-Site Locations**

REVIEW~~ED~~ DATE~~(S)~~: **5/03** **POLICY NUMBER: 204**
REVISION DATE~~(S)~~: **10/11, 5/2020**

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish a set of guidelines for Security Department personnel to utilize in the performance of their assigned duties while at ~~O~~off-~~S~~site ~~L~~locations **or notified through phone-call for assistance needed**.

B. **POLICY:**

1. It is the policy of the Security Department **(S.D.)** to utilize the following procedures in relation to ~~A~~authority that a Security Officer has at Tri-City Medical Center owned or operated ~~O~~off-~~S~~site ~~L~~locations. **The S.D. only responds / provides assistance to the off-site locations that are closest to the medical center's main campus [along Vista Way, Thunder Drive, and Waring Court]; local law enforcement agencies are to be notified if assistance is needed for the off-site locations not within a close proximity to the main campus.**

C. **PROCEDURE:**

1. Tri-City Medical Plaza, 2095 Vista Way, Vista, C~~A~~a 92083.
   a. This property is owned and operated by Tri-City Healthcare District, and all
   ~~i.~~ Security Department ~~P~~policies and ~~A~~authority extend to this ~~P~~property.
   b. If Law Enforcement assistance is needed, the San Diego Sheriffs Department will be contacted **[(760) 940-4551]**.

~~2. Outpatient Rehabilitation Services, 161 Thunder Drive, Vista, Ca 92083.~~
   ~~a. This suite is operated by Tri-City Healthcare District and all Security Department Policies and Authority only extend to within the limits of the Suite.~~
   ~~b. If Law Enforcement assistance is needed the San Diego Sheriffs Department will be contacted.~~

~~3. Operational Improvement and Service Excellence, 3927 Waring CT. Ste D, Oceanside, CA 92056~~

~~a. This suite is operated by Tri-City Healthcare District and all Security Department Policies and Authority only extend to within the limits of the Suite.~~

~~b. If Law Enforcement assistance is needed the Oceanside Police Department will be contacted~~

~~4.~~2. **Out-Patient** Forensics Unit, 3925 **Suite C,** Waring CT, Oceanside, CA 92056

a. This suite is operated by Tri-City Healthcare District, and all Security Department ~~P~~policies and ~~A~~authority only extend to within the limits of the ~~S~~suite.

b. If Law Enforcement assistance is needed, the Oceanside Police Department will be contacted **[(760) 435-4911].**

~~c.~~3. **Business Development, 3925 Suites A and B, Waring CT, Oceanside, CA 92056**

~~d.~~a. **These suites are operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suites.**

~~5.~~b. **If law enforcement assistance is needed, the Oceanside Police Department will be contacted [(760) 435-4911].**

~~a.~~4. Tri-City Wellness Center, 6250 El Camino Real, Carlsbad, CA 92009

~~b.~~a. This suite is operated by Tri-City Healthcare District, and all S~~ecurity.~~-D.~~epartment~~ ~~P~~policies ~~and/~~ ~~A~~authority only extend to within the limits of the suite.

~~c.~~b. If ~~L~~law ~~E~~enforcement assistance is needed, the Carlsbad Police Department will be contacted **[(760) 931-2100].**

~~d.~~5. **Tri-City Medical Office Building, 6260 El Camino Real, Carlsbad, CA 92009**

~~e.~~a. **This suite is operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suite.**

~~f.~~b. **If law enforcement assistance is needed, the Carlsbad Police Department will be contacted [(760) 931-2100].**

~~6. Tri-City Occupational Medicine and Wound Care Center, 6260 El Camino Real, Carlsbad, CA 92009~~

~~a. This suite is operated by Tri-City Healthcare District and all Security Department Policies and Authority only extend to within the limits of the suite.~~

~~b.~~i. ~~If Law Enforcement assistance is needed the Carlsbad Police Department will be contacted.~~

~~c.~~6. **Tri-City Primary Car Medical Group, 1926 Via Centre Drive, Vista CA 92081**

~~d.~~a. **This suite is operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suite.**

~~e.~~b. **If law enforcement assistance is needed, the San Diego Sheriffs Department will be contacted [(760) 940-4551].**

~~f.~~7. **Tri-City Orthopaedic Specialists of North County(ONSC), 3905 Waring Road, Oceanside CA 92056**

~~g.~~a. **This suite is operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suite.**

~~h.~~b. **If law enforcement assistance is needed, the Oceanside Policy Department will be contacted [(760) 435-4911].**

~~i.~~c. **O~~.~~S~~.~~N~~.~~C~~.~~ has 3 other locations: 6121 Paseo Del Norte [Ste. 200, Carlsbad, CA 92011], 1958 Via Centre Drive [Vista, CA 92081], 351 Santa Fe Dr. [Ste. 100, Encinitas, CA 92024]**

~~j.~~8. **Tri-City Out-Patient Behavioral Health , 510 Vista Way, Vista CA 92083**

~~k.~~a. **This suite is operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suite.**

~~l.~~b. **If law enforcement assistance is needed, the San Diego Sheriffs Department will be contacted [(760) 940-4551].**

~~m.~~9. **Tri-City Pulmonary Specialist of North County, 3231 Waring Court, Suite D, Oceanside CA 92056**

~~n.~~a. This suite is operated by Tri-City Healthcare District and all S.D. policies / authority only extend to within the limits of the suite.

~~o.~~b. If law enforcement assistance is needed, the Oceanside Police Department will be contacted [(760) 435-4911].

~~p.~~10. Tri-City La Costa Urology, 3907 Waring Road, Ste. 4, Oceanside CA 92056

~~q.~~a. This suite is operated by Tri-City Healthcare District, and all S.D. policies / authority only extend to within the limits of the suite.

~~r.~~b. If law enforcement assistance is needed, the Oceanside Police Department will be contacted [(760) 435-4911].

Tri-City Medical Center
Oceanside, California

SECURITY
DISASTER PREPAREDNESS

ISSUE DATE: 03/91

SUBJECT: Medical Center Power Outage Response

REVIEWED DATE(S): 09/94, 07/97, 05/03, 11/06, 03/09, 06/11, ~~07/15~~
REVISION DATE(S): 09/94, 07/03, 09/15

POLICY NUMBER: 804

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To set fourth guidelines to be utilized by Security Officers when confronted with a power outage at the Medical Center.

B. **POLICY:**

1. It is the policy of the Security Department to maintain a well-lighted environment in all areas of the Medical Center in order to ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members.

C. **PROCEDURE:**

1. Upon either notification or observation of any type of power outage, the Security Officer will immediately notify the Security Supervisor, Designee, or Shift Lead Officer of the power outage. The Security Officer will also ensure that the on-duty Engineer and Administrator or Administrative Coordinator are also informed of the power outage.
2. The Security Department will provide safety escorts to Patients, Visitors, and Staff Members throughout the Medical Center Campus Parking Areas if the power outage occurs during dark hours.
3. All Security Officers on-duty during a power outage during dark hours will maintain a high visibility, conducting frequent and random patrols of the parking areas ensuring the Safety, Security, Welfare of all Patients, Visitors, and Staff Members, including all Medical center, and Personal Property.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 22, 1991~~ ~~Reviewed: 5/91, 1/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Missing Patient (Missing Patient Search)~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM – # 212~~

ISSUE DATE: **04/91**~~April 22, 1991~~ **SUBJECT:** Missing Patient (Missing Patient Search)

REVIEWED DATE(S): **05**/91, **01**/97, **05**/03, 11/06, **03**/09, **06**/11, **05**/13 **POLICY NUMBER: 212**

REVISION DATE(S): **07**/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To redefine policies, procedures, and responsibilities governing the protection of Missing Patients.

B. **POLICY:**
1. In the event that a patient cannot be located, an immediate search plan will be implemented, coordinating the combined efforts of the Clinical Staff and Security. Reference Administrative Policy #305 Missing Patient

C. **PROCEDURE:**
1. When a patient is deemed missing, an organized search will be made, escalating in intensity, as deemed appropriate by the nurse or supervisory staff in charge the patient's unit.
2. To initiate the search the nurse in charge will contact:
   a. Management Personnel (their immediate supervisor)
   b. Security, reporting all identifying information regarding the patient.
   c. Administration
3. Nursing will coordinate an immediate search of the Patient's unit, utilizing the "Nursing Missing Patient Search Checklist".
   a. This search will include the surrounding stairwells, restrooms, showers, treatment rooms, lobbies, supply rooms, and elevator areas.
4. The Security Department will conduct a search of the Medical Center grounds using the "Security Missing Patient Search Checklist".
   a. This search will include all waiting rooms, lobbies, gift shop, designated smoking areas, cafeteria, restrooms in the immediate area, and exterior grounds.

5. Security will contact the appropriate Law Enforcement Agencies if deemed necessary. Security will also contact other designated Medical Center employees including Facilities Management and Environmental Services.
6. If the patient is located, all parties involved in the search will be immediately notified. If the patient is not located within a reasonable amount of time the search will be discontinued.

D. FORM(S):

1. **Missing Patient Search Checklist**

~~D.~~E. RELATED DOCUMENT(S)~~ATTACHMENT~~:

1. Administrative Policy #305 Missing Patient

Tri-City Medical Center
Security Department

Missing Patient Search Checklist

Patient Name:	Location Missing from:	Current Date:	Time Notified:
Patients Lask Known Location		Date Last Seen:	Time Last Seen:
Description of Missing Patient:			

Locations Checked:

Lobbies/Waiting Rooms:	Results:

Exterior/Smoking Areas:	Results:

Stairwells:	Results:

Public Areas:	Results:

Other Locations:	Results:

Revised:
Security Policy: Missing Patient #212

Tri-City Medical Center
Oceanside, California

SECURITY PERSONNEL

ISSUE DATE: 09/94~~September 30, 1994~~ **SUBJECT: New Officer Training**

REVIEW~~ED~~ DATE~~(S)~~: 01/97, 05/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 301**

REVISION DATE~~(S)~~: 07/03, 09/15

Department Approval:	**~~07/15~~05/20**
Environmental Health and Safety Committee Approval:	**~~08/15~~08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~09/15~~ n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**

1. To ensure proper training of newly hired Security Officers while in the new employee orientation ~~and~~, training phase**, and probationary period** of employment.

B. **POLICY:**

1. It is the policy of the Security Department that all newly hired Security Officers will be thoroughly trained and oriented to all duties, activities, assignments, and locations~~,~~ which are pertinent to proper job performances.

C. **PROCEDURE:**

1. On the first day of employment, every newly hired Security Officer will receive a "Training Check List".
2. The Security Supervisor**, Lead Security Officer, or Designee** will assign a ~~Field T~~training ~~O~~officer**/s** to assist in the training of the new Officer.
3. The ~~Field T~~training ~~O~~officer**/s** will explain each listed item in the Training Check List. The ~~Field T~~training ~~O~~officer**/s** will then demonstrate the proper procedure to be followed for each task. The ~~Field T~~training ~~O~~officer**/s** will then observe the new Officer perform the duties of each task.
4. Once the ~~Field T~~training ~~O~~officer is satisfied that the new Officer can successfully perform each task, they will sign and date the Training Check List item.
5. It is expected that each new Officer will complete this phase of training within thirty days of the first day of employment.
6. The completed Training Check List will be submitted to the Security Supervisor for review and placed in the employee's Security Department Personnel File. **Furthermore, the new-hire security officer will complete the department orientation checklist and verification of job competencies as per the Human Resources Department which will also be placed in the new-hire officer's employee file.**
7. **All security officers are expected and will assist with the training of all newly-hired security officers to ensure continuity of training and accountability.**

D. **FORMS:**

1. New Officer Training Check 30 Day
2. Department Orientation Checklist (Administrative 400s Form)

Tri-City Medical Center
Security Department's Officer Orientation Checklist

EMPLOYEE CONDUCT = SECTION 1

Task	Evaluator	Officer	Date
Security Officer Job Description			
Expectations			
Radio and Phone Communications			
Chain of Command = 102 and 103 S.D.P.			
Incident Notification = 208 S.D.P.			
Release of Information = 108 S.D.P.			
Identification = 436 A.P.			
Dress and Appearance = 415 A.P.			
Hair and Grooming Standards = 302 S.D.P.			

INTERIOR AND EXTERIOR WHEREABOUTS = SECTION 2

Task	Evaluator	Officer	Date
Internal Levels and Towers and Departments			
Sensitive Areas = 502 S.D.P.			
Exterior Buildings and Parking Lots and Off-			

DEPARTMENT OPERATIONS AND POLICIES = SECTION 3

Task	Evaluator	Officer	Date
Emergency Department Lobby			
Emergency Department Station B			
Mobile Patrol			
Interior Rover Patrol			
Main Entrance			
Crisis Stabilization and Behavioral Health Units			
Lead Security Officer			
Posts' Rotation Schedule			
Lost and Found and Valuables			
Morgue Releases			
Service Animal			
Helicopter and Aero Medical Transport			
Request of Unlock			

HEALTHCARE DISTRICT AND PERSONAL LIABILITIES = SECTION 4

Task	Evaluator	Officer	Date
Patient Interaction = 211 S.D.P.			
Patient Stand-By = 214 S.D.P.			
High-Risk Patient or Visitor = 509 S.D.P.			
Psychiatric Patient Escorts = 216 S.D.P.			
Use of Force = 209 S.D.P.			

T.C.M.C. Security Department's Officer Orientation Checklist [continued]

HEALTHCARE DISTRICT AND PERSONAL LIABILITIES = SECTION 4 [continued]

Task	Evaluator	Officer	Date
Arrest and Detention Authority = 210 S.D.P.			
Incident Report Example			
Missing Patient Search = 212 S.D.P.			
Fleeing Patients / Elopement = 213 S.D.P.			
Incident Report Example			
Psychiatric Hold			
Instructional Order			
Physical Contact Reasons			
Incident Report Example			

LAW ENFORCEMENT AND RISK MANAGEMENT INTERACTIONS= SECTION 5

Task	Evaluator	Officer	Date
Dangerous Weapons = 508 S.D.P.			
Drugs and Paraphernalia = 506 S.D.P.			
Seized Contraband or Evidence = 231 S.D.P.			
Arrest and Detention Authority = 210 S.D.P.			
Trespassing			
Unusual or Adverse or Sentinel Events			

DOCUMENTATION STANDARDS = SECTION 6

Task	Evaluator	Officer	Date
Security Officer Documentation = 238 S.D.P.			
Daily Reports and Field Notes			
Incident Reports and Field Investigations			
Templates			
Incident Report Examples			
Grammar and Punctuation			
Mock Reports			
Typed Statements			

EMERGENCY PREPAREDNESS = SECTION 7

Task	Evaluator	Officer	Date
Code Silver or Active Shooter = E.P.M.P. Section			
Doctor Strong = 221 A.P.			
Code Red or Fire = 504 S.D.P.			
R.A.C.E. and P.A.S.S. and Fire Doors			
Panic Alarms = 221 S.D.P.			
Entry Alarms = 220 S.D.P.			
Code Orange Response = 4026 E.P.M.P.			
Code Adam = 503 S.D.P.			

T.C.M.C. Security Department's Officer Orientation Checklist [continued]

EMERGENCY PREPAREDNESS = SECTION 7 [continued]

Task	Evaluator	Officer	Date
Bomb Threat or 7575 = 4013 E.P.M.P.			
Code Gray or Hostage = 505 S.D.P.			
Earthquake = 4010 E.P.M.P.			
Delegated Authority = 107 S.D.P.			
Emergency Incident Officer Recall = 803 S.D.P.			

ADMINISTRATIVE COMPETENCIES = SECTION 8

Task	Evaluator	Officer	Date
Microsoft Outlook and Email Communication			
Kronos and Timecard Completion			
Schedule and Paid Time off and Overtime			
Shift Trade Agreements			
Computer Based Learning Modules			
Job Orientation and Job Competencies			
Security Department Trailer Orientation			

Trainee / Date

_____

Evaluator / Date

_____

Tri-City Medical Center

SECURITY DEPARTMENT

New Officer Training Check – 30 Day

Officer: _____ **Employee Number:**

Task:	Pass / Fail				Evaluator:	Officer:	Date:
How to Arrange Additional Security Coverage		Pass		Fail			
Duress Alarm Response (Panic Alarms)		Pass		Fail			
Duress Alarm Locations (Panic Alarms)		Pass		Fail			
Animal In Medical Center		Pass		Fail			
Announced Fire Alarm Response		Pass		Fail			
Appearance and Uniforms		Pass		Fail			
Powers of Arrest		Pass		Fail			
Service of an Arrest Warrant		Pass		Fail			
Attendance and Punctuality		Pass		Fail			
CCTV Locations		Pass		Fail			
Civil Disturbance		Pass		Fail			
Communications		Pass		Fail			
Crime Scene Protection		Pass		Fail			
Critical Incident Response Plan		Pass		Fail			
Detention By Security		Pass		Fail			
Disaster Preparedness		Pass		Fail			
Discovered Fire Response		Pass		Fail			
5150 Control		Pass		Fail			
Door Unlock Request		Pass		Fail			
Security Officer Job Description		Pass		Fail			
Employee Contacts		Pass		Fail			
Equipment/Gauge Checks		Pass		Fail			
Nursing/Security Relationship		Pass		Fail			
Facility Doors		Pass		Fail			
Security Sensitive Areas		Pass		Fail			
Forensic/Prisoner Training For Custody Officer		Pass		Fail			
Lost and Found Property		Pass		Fail			
Aero Medical Detail (Mercy Air)		Pass		Fail			
Hostage Situation		Pass		Fail			
Injured Person Contact		Pass		Fail			
Meal and Rest Periods		Pass		Fail			
Missing Property		Pass		Fail			
Morgue Detail/Duties		Pass		Fail			
Emergency Department Duties		Pass		Fail			
On-The-Job Injury or Illness		Pass		Fail			
Patrol/Inspection		Pass		Fail			
Parking Control		Pass		Fail			
Behavioral Health Department STAT Response		Pass		Fail			
Traffic Control		Pass		Fail			
Patient Contacts		Pass		Fail			

Tri-City Medical Center
SECURITY DEPARTMENT

Officer Evaluation

Officer: _____ Employee Number: _____

Task:	Pass / Fail				Evaluator:	Officer:	Date:
Persons Needing Non-Emergency Police Assistance		Pass		Fail			
Restraint Training		Pass		Fail			
Security At Shift Change		Pass		Fail			
Police Contacts		Pass		Fail			
Property Removal		Pass		Fail			
Request for Sensitive or Confidential Information		Pass		Fail			
Search by Security after an Arrest		Pass		Fail			
Security Alarm Locations		Pass		Fail			
Security Key Ring		Pass		Fail			
Security Mission Statement		Pass		Fail			
Security Lead Job Description		Pass		Fail			
Security Surveillance		Pass		Fail			
Security Report Forms		Pass		Fail			
Security Staffing Plan		Pass		Fail			
Lock/Unlock Schedules		Pass		Fail			
Seizure of Property By Security		Pass		Fail			
Serious Incident Notification		Pass		Fail			
Sexual Harassment		Pass		Fail			
Solicitation & Distribution of Literature		Pass		Fail			
Timed Duties		Pass		Fail			
Tobacco Use		Pass		Fail			
Use of Appropriate Force		Pass		Fail			
Valuables Escort		Pass		Fail			
Vehicle Accident on TCMC Property		Pass		Fail			
Vehicle Battery Jump (Battery Pack to Vehicle)		Pass		Fail			
Vehicle Battery Jump (Car to Car)		Pass		Fail			
Vehicle Door Unlock		Pass		Fail			
Vehicle Lights On		Pass		Fail			
Vehicle Re-Park		Pass		Fail			
Vehicle Tire Change		Pass		Fail			
Vehicle Use		Pass		Fail			
Very Important Patient (VIP)		Pass		Fail			
Visitor Contacts		Pass		Fail			
Weapons On Campus		Pass		Fail			

Officer: _____ Date: _____

Evaluator: _____ Date: _____

Supervisor: _____ Date: _____

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: July 10, 2002~~ ~~Reviewed: 8/02, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Patient Stand-By~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 214~~

ISSUE DATE: 07/02~~July 10, 2002~~ **SUBJECT: Patient Stand-By**

REVIEW~~ED~~ DATE~~(S)~~: 08/02, 05/03, 11/06, 03/09, 06/11, 05/13 **POLICY NUMBER: 214**

REVISION DATE~~(S)~~: 7/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish a clear set of guidelines for Security Officers to utilize when conducting a Patient Stand-By.

B. **POLICY:**
1. It is the policy of the Security Department that all Security Officers will utilize the following procedure when conducting a Patient Stand-By

C. **PROCEDURE:**
1. **Patient Stand-By**
   a. When Security is requested to do a patient stand-by the Officer responsible for the area will respond to the location and assess the situation. If needed the responding Officer will request the assistance of additional Officer(s).
   b. If the patient does not pose a threat to Staff, Patients, or Visitors the Officer may clear from the area when they feel that there assistance is no longer needed.
2. **Patient Stand-By for Psychiatric Patients Not on a 5150 Hold**
   a. When Security is requested to do a patient stand-by for a Psychiatric Patient that is NOT on a 5150 hold, the Officer responsible for the area will respond and assess the situation. If needed the responding Officer will request the assistance of additional Officer(s).
   b. If the Patient has expressed combative behavior Security will stand-by and assist Medical Staff as needed.

c. If the Patient has not expressed any combative behavior and has not exhibited any problems, the Officer(s) may clear the area when they feel their assistance is no longer needed.

3. **Patient Stand-By for Psychiatric Patients on a 5150 Hold**

a. When Security is requested to do a stand-by for a Psychiatric Patient who is on a 5150 hold, the Officer responsible for the area will respond and assess the situation. If needed the responding Officer will request the assistance of additional Officer(s).

b. If the Patient has expressed combative behavior Security will stand-by with the Patient whenever there is any interaction between the Patient and Medical Staff. Security will also inform the Charge Nurse of the Patient's actions and if needed will recommend that the Patient be placed in a Secure Location for the safety of all Patients, Staff, and Visitors (i.e. Room B-11 with door secured or other seclusion area).

c. If the Patient has not expressed combative behavior or exhibited any problems, the Officer(s) will stand-by as needed anytime there is interaction between the Patient and Medical Staff.

d. If the Patient has exhibited the desire or has attempted to elope from the immediate patient care area, Security will notify the Charge Nurse of such actions and recommend the Patient be placed in a Secure Location (i.e. Room B-11 with door secured, or other seclusion area).

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE:	**05/11**	**SUBJECT:**	**Patient Valuables Collection and Return**
REVIEW~~ED~~ DATE~~(S)~~:		**06/11, 07/15**	**POLICY NUMBER: 237**
REVISION DATE~~(S)~~:	**09/15**		

Department Approval:	**~~07/15~~05/20**
Environmental Health and Safety Committee Approval:	**~~08/15~~08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~09/15~~ n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel to utilize when receiving Patient Valuables.

B. **POLICY:**
1. It is the policy of the Security Department to utilize the following procedure when receiving, returning, and disposing Patient Valuables.

C. **PROCEDURE:**
1. Receiving Patient Valuables
   a. When Security is requested to collect patient valuables, the responding Security Officer will first encourage the patient to send the item(s) home with a family member for safe-keeping.
   b. If the patient is unable or unwilling to send the item(s) home for safe keeping, the Officer will bring a grey UniVault bag to the location of the patient. The Officer will collect the item(s) with the patient's nurse as a witness to the collection process. Once the item is collected, the Officer will inventory the item(s) and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it. Only valuables will be collected and placed in the bag (i.e. if the patient is securing a wallet, the valuables are removed from it in the patient's presence, and placed in the UniVault bag, then the wallet is returned to the patient.) All information on the bag must be filled out completely, and signed by the patient. If the patient is unable to sign, the patient's nurse will sign as a witness. The top flap portion of the bag is to be removed and filled out, then given to the patient as receipt of collection. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the Patient's Nurse to be included in the Patient's chart, and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office. The Officer must verify the patient's phone number with the patient (not collected from the chart) to ensure current and accurate contact information.
   c. All applicable information will be logged into the **Patient Valuables Property Logbook #4** including the patient's name, phone number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.

2. Returning Patient Valuables.
   a. When requested to return a patient's valuables, every attempt will be made to ensure that the item(s) is/are being returned to the proper owner.
   b. The Officer will collect the UniVault receipt from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the patient's chart.
   c. The Officer will take the UniVault receipt or chart copy and contact the Cashiering Department or Administrative Coordinator (After Hours) to meet and open the Small (Drop) Safe to collect the patient's valuables. The Officer will return to the floor and in the presence of the patient and nurse, will cut the bag open on the dotted line of the bag. The Officer will inventory the contents of the UniVault Bag and compare them to the inventory listed on the outside of the bag while checking off the inventory items. When the patient is satisfied that all their valuables are accounted for, the Officer will have the patient sign the UniVault Bag and the copy. The Officer will make two copies of the signed inventory sheet and give to the patient's nurse to be included in the patient's chart as a permanent record of receipt.
   d. The Officer will return the signed UniVault Bag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above small (Drop) safe.
   e. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, and file them together in the Disposition section of Patient Valuables filing cabinet.
3. Destruction of Patient Valuables Property
   a. If any patient valuables items are not claimed within 180 days, the items will be disposed of in a manner specified by the Director of the Risk, Legal, and Regulatory Department.

D. **RELATED DOCUMENTS:**

1. Patient Care Services Policy ~~(formerly #317)~~: Patient Valuables Liability and Control

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 04/94 **SUBJECT: Patrol of Areas Under Construction**

REVIEWED DATE(S): 12/96, 12/01, 05/03, 11/06, 07/15 03/09, 06/11, **POLICY NUMBER: 226**
REVISION DATE(S): 12/01, 07/03, 09/15

Department Approval:	**07/15 05/20**
Environmental Health and Safety Committee Approval:	**08/15 08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**09/15 n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**
1. To ensure that areas under construction are safe and secure for all staff, visitors, and patients who might frequent the location.

B. **POLICY:**
1. It is the policy of the Security Department that all on-duty Security Officers will randomly patrol all areas under construction for any situation or condition, which would jeopardize the safety, security, and welfare of any staff, visitor, and patient at the Medical Center.

C. **PROCEDURE:**
1. All on-duty Security Officers will routinely and randomly patrol all areas under construction, which are located in their assigned area of responsibility.
2. When a situation or condition, which creates a hazard, is detected, the Security Officer will immediately take the necessary corrective action. This includes but is not limited to, notification of the on-duty engineer, the placing of barricades, tape, etc. to secure the location.
3. If this situation or condition is detected during normal business hours, the Special Projects coordinator, of the Facilities Management Department will be contacted and advised of all pertinent information.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 01/94 **SUBJECT:** Personal Safety Escort for Visitors and Staff

REVIEW~~ED~~ DATE~~(S)~~: 10/97, 05/03, 11/06, 03/09, 06/11, 07/15 **POLICY NUMBER:** 514
REVISION DATE~~(S)~~: 7/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**
1. To establish guidelines for all Security Department personnel while conducting an escort Medical Center Patients, Visitors, and Staff Members.

B. **POLICY:**
1. Whenever possible, it is the policy of the Security Department, that all ON-Duty Security Officers will perform personal safety escorts for Patients, Visitors, and Staff Members from the Medical Center to their vehicle or other means of transportation.

C. **PROCEDURE:**
1. If Possible, all On-Duty Security Officers will be available to provide personal safety escorts when requested for Patients, Visitors, and Staff Members.
2. If an escort request is received over the Security Department radio system, the Officer having responsibility for the escort request area will, if possible, respond and make personal contact with the requesting party.
3. If the responsible Officer is unable to respond, PBX will be immediately notified and advised of the Officers estimated time of arrival.
4. If during any escort, the Officer receives an emergency or high priority call, the Officer will immediately terminate the escort and respond to the location of the call.
5. All escorts will be performed in a timely, polite, and professional manner.
6. All escorts will be documented on the Officer's Daily Security Report.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: June 06, 1991~~ ~~Reviewed: 5/94, 10/97, 5/03, 11/06, 03/09, 5/13~~ ~~Revision: 5/94, 7/03, 06/11, 04/13~~ ~~Approvals: Director of Security~~	~~Subject: Security Shift Post Positions~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 202~~

ISSUE DATE: 06/91~~June 06, 1991~~ **SUBJECT:** ~~Security Shift~~ Post Positions

REVIEWED DATE(S): 05/94, 10/97, 05/03, 11/06, 03/09, 05/13 **POLICY NUMBER: 202**

REVISION DATE(S): 05/94, 07/03, 06/11, 04/13

Department Approval:	05/20
Environmental Health and Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To assist each Security Officer with guidelines of activities, details, and assignments for all Security Department ~~Shift~~ ~~P~~post ~~P~~positions.

B. **POLICY:**

1. It is the policy of the Security Department that each Security Officer be familiar with and able to demonstrate proficiency in assuming the assignment of any ~~Shift~~ ~~P~~post position.

C. **PROCEDURE:**

1. The following is an overall breakdown of the basic responsibilities and responsibilities of each Security Department ~~Shift~~ ~~P~~post ~~P~~position. All positions include other duties as identified and assigned by the ~~Hospital Safety Officer~~ **Security Department Manager, Supervisor, and S.D. Leadership members** to enhance overall productivity and Department efficiency.
   - ~~a. Shift Lead Officer. The Shift Lead Officer is designated by the Security Supervisor or Designee to act as the Charge Officer in the absence of the Security Supervisor. The Shift Lead Officer is in charge of all Security Department Operations in the absence of the Security Supervisor.~~
   - ~~b. 1-Post Officer. The 1-Post Officer is responsible for the West Side of the Medical Center and all calls for service in that area.~~
   - ~~c. 2-Post Officer. The 2-Post Officer is responsible for the East Side of the Medical Center and all calls for service from that area of the Medical Center.~~
   - ~~d. 3-Post Officer. The 3-Post Officer is assigned to the Emergency Department and Mental Health Unit. The 3-Post is responsible for all calls for service from the Emergency Department and Mental Health Unit. The 3-Post is responsible for all 5150~~

~~Patients and In-Custody Patients in the Emergency Department, Mental Health Unit, and throughout the Medical Center. The 3-Post will ensure that all Custody Officers have properly completed the Forensic Training Services form.~~

~~e. 4-Post, and additional Security Department personnel. All additional personnel are assigned to both the East and West Side of the Medical Center, providing constant patrols and assisting with calls for service as needed or directed by the Shift Lead Officer.~~

~~a.~~ ~~6-Post Officer's primary objective is to post in the Emergency Room Lobby near the Triage Nurse Station and entrance to the Emergency Room Lobby. The Officer will observe any activity that could cause a disturbance or other high risk behavior, and immediately report it to the Security Supervisor, Shift Lead, or designee via hand-held radio while actively maintaining the safety and wellbeing of the patient, visitors, and medical staff.~~

b. The following post orders include but are not limited to the following guidelines and prcedures.

c. Eastside Main Entrance: engage passers-by and stay aware of Main Lobby, Level 1 Hallways, exterior-side of East Main Entrance [Sector 8], provide directions for customers and visitor badges, assist with reviewing C.C.T.V., notifying the Legal Department and lead security officer of subpoenas, and responds to all emergency calls on property.

d. Westside Emergency Department Lobby and Weapons' Scanner: inventory personal items and persons' body that enter into the Lobby [visually or physically with flashlight, drumstick, or metal-detector / wand], be aware of high-risk persons near the E.D. area, and assist with reviewing C.C.T.V.

e. Emergency Department Station B: in the best possible position to stop elopements, stop combative patient, to monitor all high-risk activity, ensure that all high-risk patients are congregated together and not dispersed throughout the E.D., and is able to respond to emergency calls on property if authorized by Supervisor, Lead, or designee.

f. E.D. Rover: responsible for patrolling all E.D. patient care areas, hallways, Ambulance Bay and Unloading / Loading Zone outside the E.D. [Sector 15], assist the scanner officer in the E.D. Lobby, assist the E.D. Station B officer with authoritative presence and watching high-risk patients, responsible for coordinating Station B and E.D.S.O. operations i.e. enforcement reports, C.C.T.V. checks, and visitors' badges, and responds to all emergency calls on property.

g. Interior Rover: responsible for patrolling all patient care areas, stairwells, lobbies, bathrooms, hallways, Cafeteria, departments, and roof-top access points, checking/confirming the whiteboard information e.g. purple horseshoe patients, custody patients, closed floors, and hold patients, assist with all internal calls for assistance as well as relieve other security officers for assistance, and responds to all emergency calls on property.

h. Exterior Rover: responsible for providing mobile presence throughout all parking lots, giving escorts to different access points of the hospital, directing outside agencies [i.e. law enforcement or fire department] to access points / departments within the hospital, responsible for identify possible threats or incidents around the hospital's perimeter e.g. Thunder Drive, Vista Way, and Waring Court streets, and responds to all emergency calls on property.

~~f.~~i. Any non-adherence to these guidelines / procedures will incur discipline up to possible termination.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: September 15, 1997~~ ~~Reviewed: 12/99, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 12/99, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Preventative Maintenance Program~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM # 110~~

ISSUE DATE: 09/97~~September 15, 1997~~ **SUBJECT:** **Security Department Preventative Maintenance Program**

REVIEW~~ED~~ DATE: **12/99, 05/03, 11/06, 03/09, 6/11,-05/13** **POLICY NUMBER: 110**
REVISION DATE: **12/99, 7/03**

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To describe the process by which the Security Department will systematically inspect, and if necessary repair and/or replace security related equipment.

B. **POLICY:**
1. The Security Department has developed a systematic and time generated inspection process for all security related equipment, so that each item will function properly and effectively assist in establishing a safe and secure environment for all staff, visitors and patients at the Medical Center.

C. **PROCEDURE:**
1. Portable Radio Communications System – Daily Inspection
   a. At the beginning of each shift, all security officers will be responsible for checking out and conducting a brief radio check of the hand-held portable radio, to ensure proper transmitting and receiving capabilities. In addition, the officers will be responsible for conducting a physical inspection of the following radio components for any damage or defects that could cause the unit to malfunction:
      i. The exterior radio case.
      ii. The radio speaker microphone and attached plug wires.
      iii. The radio antenna and attachment screw plug.

b. If any unit component is found to have a malfunction, the security officer will be responsible for completing any required departmental report and forward to the Security Supervisor/designee for process and repair authorization.

2. Security Vehicles – Daily Inspection
   a. At the beginning of each shift, each officer utilizing a security vehicle will properly inspect the vehicle. Vehicles will only be used when in good repair and in a condition that will ensure the safety, security and welfare of all staff, visitors and patients.
   b. The utilizing officers will be responsible for properly complying with all requirements, as outline in of sub-section 3.1.2. In addition, the current designated departmental vehicle coordinator will also be contacted and informed of the problem.
   c. During the utilizing officer's shift, if the vehicle malfunctions, it will be immediately secured and utilized until all necessary repairs and/or service has been completed.
3. Closed Circuit Television System – Semi Annual Inspection
   a. It will be the responsibility of the Night shift security officer assigned to the Emergency Department to inspect the system and ensure that all components are in good working order.
   b. In the event of a system or component malfunction, the officer will comply with all requirements as outlined in sub-section 3.1.2. In addition, the detecting officer will be responsible for contacting and informing the current, designated, departmental CCTV coordinator of the problem.
   c. The CCTV coordinator/designee will be the point-of-contact for the removing, reviewing and documenting the release of any recorded CCTV video for evidentiary purposes.
   d. The CCTV coordinator will be responsible for ensuring that all proper documentation, pursuant to the preventive maintenance program is completed and entered into the appropriate binder on a semi-annual basis.
4. Security Alarm System – Semi Annual Inspection
   a. It will be the responsibility of the Security Supervisor/designee to ensure that all intruder alarm system locations are in good working order.
   b. The Security Supervisor/designee will be responsible for ensuring that this inspection process is completed and documented in the verification binder on a semi-annual basis.
5. Panic Alarm System – Semi Annual Inspection
   a. It will be the responsibility of the Security Supervisor/designee to ensure that all panic button alarm locations are in good working order.
   b. The Security Supervisor/designee will be responsible for ensuring that any system or component malfunction is repaired or replaced in a timely manner.
   c. The Security Supervisor/designee will be responsible for ensuring that this inspection process is completed and documented in the verification binder on a semi-annual basis.
6. Combination Locks – Semi Annual Inspection
   a. It will be the responsibility of the Security Supervisor/designee, in conjunction with the Medical Center locksmith, for ensuring that all combination locks are in good working order.
   b. The Security Supervisor/designee will also be responsible for ensuring that a current database printout listing all lock locations, is distributed to and reviewed by all security officers. Due to the sensitive/confidential nature of this data, no information will be disseminated to any non-security personnel without the approval and authorization of the Security Supervisor/designee.
   c. The Security Supervisor/designee will be responsible for ensuring that any system or component malfunction is repaired or replaced in a timely manner.
   d. The Security Supervisor/designee will be responsible for ensuring that this inspection process is completed and documented in the verification binder on a semi-annual basis.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 11/92 **SUBJECT:** Property Custody

REVIEWED DATE(S): 04/94, 10/97, 05/03, 11/06, 03/09, 06/11 **POLICY NUMBER:** 232
REVISION DATE(S): 7/03, 09/15

Department Approval:	**~~07/15~~05/20**
Environmental Health and Safety Committee Approval:	**~~08/15~~08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**~~09/15~~ n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department personnel to utilize in association with the impounding of any property or property seized for safekeeping.

B. **POLICY:**
1. It is the policy of the Security Department to ensure that all items impounded or seized for safekeeping are properly logged and secured.

C. **PROCEDURE:**
1. Impounding of Dangerous Weapons
   a. Anytime an Officer observes or learns of a Dangerous Weapon on the Medical Center, the Officer will seize the item and place it into the Locked Cabinet in the Emergency Department Security Office. A Property Custody form will be completed and a copy given to the owner.
2. Items seized for Safekeeping
   a. Any time an Officer seizes any item or takes into custody an item for Safekeeping the Officer will complete a Property Custody for and give a copy for the owner.
   b. The collection or disposition of questionable items will be at the discretion of the Lead or Designee.
3. Storage of Weapons on Medical Center Campus.
   a. Anytime a request is made to secure a weapon by a registered and legal carrier, the Security Officer will make sure that the weapon is made safe and secure the weapon in the Emergency Department locked cabinet. The Officer will complete a Property Custody form and give a copy to the owner.
4. Returning Property in Custody of the Security Department.
   a. When property in custody of the Security Department is requested to be returned the Officer will only return the item if the requester is ready to leave the Medical Center.
   b. The Officer will ensure that the person requesting the property is the owner or has been authorized by the owner to retrieve the property in custody. The requester should have a copy of the Property Custody form.
   c. The Officer will have the receiving party sign the original copy of the Property Custody form indicating that they are retrieving all the property.

D. **FORM(S):**
1. Property Custody Record

Tri-City Medical Center
Security Department

Property Custody Record

Notice to Property Owner: Upon release from the Tri-City Medical Center it will be your responsibility to make arrangements to pick up the hereon-listed items from the Security Department. Any items not picked up within thirty(30) days will be destroyed.

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

❑ Owner: _____

❑ Other: _____

Location / Reason Property Obtained:

_____

_____

_____

❑ Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

❑ Property Returned to Owner
❑ Property Returned to Other — Reason: _____
❑ Property Destroyed After Thirty(30) Days
❑ Property Destroyed Before Thirty(30) Days — Reason: _____

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

White: Security Department - Yellow: Person Receiving Property - Pink: Receipt

Revised:
Security Policy: Property Custody

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 30, 1991~~ ~~Reviewed: 5/94, 1/97, 9/00, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Protective Patient Restraints~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 217~~

ISSUE DATE: April 30, 1991 **SUBJECT:** **Protective Patient Restraints (Violent and Non-Violent)**

REVIEW~~ED~~ DATE~~(S)~~: 05/94, 01/97, 09/00, 05/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 217**

REVISION DATE~~(S)~~: 07/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**05/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To familiarize all Security Department personnel with the current Administrative ~~and~~, Patient Care**, and Security Department** Policies and Procedures regarding protective patient restraints **for both violent and non-violent behavior**.

B. **POLICY:**

1. It is the policy of the Security Department to follow all Administrative, Patient Care, and Security Department Policies and Procedures regarding the application of protective patient restraints.

C. **PROCEDURE:**

1. Security Department personnel will be responsible for being familiar with and able to demonstrate proficiency in the application of protective patient restraints **[both violent (hard plastic-type material) and non-violent (soft linen-type material]** and the policies governing protective patient restraints.
2. Security Department personnel will be required to follow and be familiar with the attached Administrative and Patient Care Policies and Procedures concerning Protective Patient Restraints.
3. **All security officers will receive training [verbal and physical application practices] in order to safely apply and minimize physical injury when applying restraints. This will be documented in the security officer's training period and on the officer's training checklist during their probationary period.**

4. **All security officers will also apply Non-Violent Crisis Intervention [N.V.C.I.] physical restraint techniques while the protective patient restraints are being applied to only the limbs [wrists and ankles] of the person being restrained.**
5. **Any use of restraint will be documented in the officer's daily security report in addition to an enforcement report if needed.**
~~2.~~6. **Any non-adherence to this policy could incur discipline up but not limited to termination.**

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

1. Patient Care Services Policy: **Restraints Used for Non-Violent Non-Self Destructive Behavior~~IV.Q~~**
~~1.~~2. **Patient Care Services Policy: Restraints-Seclusion for Violent-Self-Destructive Behavior**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: October 15, 1992~~ ~~Reviewed: 5/94, 10/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Release of Security Department Information~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 108~~

ISSUE DATE: 10/92~~October 15, 1992~~ **SUBJECT:** **Release of Security Department Information**

REVIEWED DATE: 05/94, 10/97, 05/03, 11/06, 3/09, 06/11, 05/13 **POLICY NUMBER: 108**

REVISION DATE: 07/03

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish the proper procedure to be utilized when a request is received for the release of any Security Department reports or information.

B. **POLICY:**
1. It is the policy of the Security Department that all Security Department **information,** reports, memos, correspondences, and e-mails will be considered confidential and as a result will not be released unless authorized in accordance with this policy.

C. **PROCEDURE:**
1. Security Department reports and information are to include but are not limited to any Crime Report, Incident Report, Accident Report, Daily Security Report, Correspondence, Memo E-Mail, Written Notes, **Witness Statement,** or any other Security Department related Information.
2. All Security Department reports **and information** will be considered confidential and will not be released by any officer. **The approved leadership member ~~[~~(Manager or Supervisor~~]~~) may release the information upon consideration.**~~unless the Officer has expressed permission to release the information from the Security Supervisor or Designee.~~
3. During the course of each Security Officer's shift, the Officer will ensure that all actions and investigations are properly documented on the appropriate Security Department report form in accordance with the current report format.

4. Any interested party not associated with the Medical Center requesting the release of any Security Department information must submit their request to the Risk Management, **Legal, or Human Resources** -Departments. (i.e. a copy of a vehicle accident report). **Only a Security Department Leadership Member [Manager or Supervisor] may release the requested information after receiving approval from the above-mentioned departments.**
5. Any request for Security Department information made by a member of the Medical Center regarding the Medical Center will be forwarded to the **Risk Management, Legal, or Human Resources Departments. The Security Department Leadership Member also has the authorization to release information.** ~~Security Supervisor, Designee, or Shift Lead Officer for approval.~~ If approved, the information will be released to the requesting party. (i.e. request for a copy of a report about an employee issue made by a Director or Supervisor)
6. Any request for Security Department information made by a member of the Medical Center regarding a personal issue will be forwarded to the Risk ~~Management~~ **Management, Legal, or Human Resources** Departments.
7. **Any non-adherence to this policy could lead to discipline up to termination.**

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

~~6.~~1. **Administrative Policy: Hospital Records Retention 237**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: January 21, 1992~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Retention of Security Department Records and Reports~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 109~~

ISSUE DATE: **01/92**~~January 21, 1992~~ **SUBJECT:** Retention of Security Department Records and Reports

REVIEWED DATE: **0**4/94, 10/97, **0**5/03, 11/06, **0**3/09, **0**6/11, **0**5/13 **POLICY NUMBER: 109**
REVISION DATE: **0**7/03

Department Approval: **05/20**
Environmental Health and Safety Committee Approval: **08/20**
Administration Approval: **10/20**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval:

A. **PURPOSE:**
1. To establish the length of time that the Security Department is responsible for the retention of Security Department Records and Reports.

B. **POLICY:**
1. To ensure that Security Department reports and records, which could be utilized for future consideration, are properly maintained for an appropriate length of time. Reference Administrative Policy #237 Hospital Records Retention

C. **PROCEDURE:**
1. It will be the responsibility of the Security Supervisor or Designee to maintain all Security Department reports and records that may be utilized for future reference, for a period of ten years.
2. These reports and records will be maintained in such a manner as to guarantee prompt retrieval if necessary.
3. The method of storage and location of storage will be left to the discretion of the Security Supervisor or Designee and will be evaluated and reviewed on a yearly basis

D. **RELATED DOCUMENT(S)**~~**ATTACHMENT:**~~
1. Administrative Policy**: Hospital RecordsRetention** #237

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 05/93 **SUBJECT:** Safety and Security Incident Investigation

REVIEWED DATE(S): 05/94, 10/97, 05/03, 11/06, 03/09, 06/11, ~~07/15~~ **POLICY NUMBER: 233**
REVISION DATE(S): 7/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**
1. To assist all Security Officers with a standardized method for the investigation of Safety and Security related incidents.

B. **POLICY:**
1. Upon notification of a Safety or Security related incident the responding Security Officer will investigate, document, and take any immediate action to ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members.

C. **PROCEDURE:**
1. Upon arrival the responding Officer will assess the scene to determine if any medical assistance or other support personnel is needed.
   a. If the Medical Center Emergency Department is unable to respond, an immediate 911 request will be made through PBX.
2. The responding Officer will be responsible for the following.
   a. Securing the incident area.
   b. Contacting all involved parties.
   c. Contacting any incident witnesses
3. The responding Officer will ensure that an Incident Report is completed in a timely manner containing all pertinent information. If an Officer is unable to generate an incident report by the end of his shift, a draft report is acceptable at the Shift Lead's discretion, with a final report generated within 48 hours.
4. If appropriate the responding Officer will insure that the area is properly documented through photographs and that the photographs are attached to a Photograph Description form containing the following information.
   a. The Incident Description.
   b. The Incident Date and Time.
   c. Any Names if Applicable.
   d. The Officer's Initials and ID Number.
5. If necessary, Administration or the Administrative Supervisor will be informed of the incident and any related information.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2003~~ ~~Reviewed: 11/06, 3/09, 6/11, 5/13~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Search of Property on Medical Center Campus~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 207~~

ISSUE DATE: 05/03~~May 05, 2003~~ **SUBJECT:** **Search / Inventory of Property on Medical Center Campus**

REVIEW~~ED~~ DATE~~(S)~~: 11/06, 03/09, 06/11, 05/13 **POLICY NUMBER: 207**
REVISION DATE~~(S)~~:

Department Approval: 05/20
Environmental Health and Safety Committee Approval: 08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel to utilize when requested to assist with the search of property on the Medical Center Campus.

B. **POLICY:**
1. Tri-City Healthcare District reserves the right to search ~~or~~, inspect**, or inventory** all property~~,~~ which it owns~~, or~~ which is found on its premises**,** and **may ask to search, inspect, or inventory** property **of a patient or** ~~in~~ an employee~~'s control or possession~~ **if deemed a safety risk**.

C. **PROCEDURE:**
1. Anytime **the** Security **Department** is requested to assist with the search of any property on the Medical Center campus, the responding Security Officer will ensure that the following are completed.
   a. The responding Security Officer will ensure that the Supervisor, Manager, or Director having responsibility over the area or employee **is notified and / or requested to be present during the investigation**.
   b. The responding Security Officer will advise the Security Supervisor, Shift Lead Officer or Designee of the ~~S~~search and any assistance requested.
   c. If searching any personally owned property of a patient or employee, verbal consent must be given first unless an urgent safety-matter must be addressed regarding the property. If law enforcement is needed, the appropriate law enforcement agency will be contacted for assistance in gaining cooperation from the owner.

~~b.~~**d. Searching of Tri-City property, e.g. beds, rooms, cabinets, lockers, etc., is authorized and does need approval by the person in question.**

2. Any **employee** property removed from any location will immediately be inventoried and turned over to the Supervisor, Manager, or Director having responsibility over the area or employee.
3. **The Security Department must have a reasonable assumption that a search of property is needed due to a safety-issue e.g. possession of a weapon or contraband. An observation of the weapon or contraband is needed by the Security Department or an overhead confession of such items by any person on property.**
4. **The Security Department has the right to ask that the property be taken off of its premises if the owner does not provide consent for a search / inventory of property based on the reported safety issue.**

~~2.~~**5. Any patient / visitor property removed from any location will immediately be inventoried and kept within the Security Department's possession until a time where it can be safely surrendered to a law enforcement personnel or given to an authorized friend / family member as per the patient's / visitor's request.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 09/91 **SUBJECT: Security Alarm Systems Response**

REVIEWED DATE(S): 04/94, 10/97, 05/03, 11/03, 11/06, 03/09, 06/11, ~~07/15~~ **POLICY NUMBER: 220**
REVISION DATE(S): 7/03, 11/03, 09/15

Department Approval: ~~07/15~~0520
Environmental Health and Safety Committee Approval: ~~08/15~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: ~~09/15~~ n/a
Board of Directors Approval: 09/15

A. **PURPOSE:**

1. In order to ensure the safety and security of sensitive and off-site locations the Security Department continually evaluates all locations and properties of the Medical Center for the need of a Security Alarm System to detect unauthorized or unlawful entry into an area of the Medical Center

B. **POLICY:**

1. Currently the Security Department utilizes Security Alarm Systems to detect Unauthorized or Unlawful entry into a Medical Center location. It is the responsibility of each Security Officer to know the location and disarm code for each Security Alarm System in the Medical Center and in all of the off-site locations.

C. **PROCEDURE:**

1. Currently Security Signal Devices Incorporated (SSD) is the Installer, Maintainer, and Monitor of the Medical Center Security Alarm Systems.
2. In the event of an Unauthorized or Unlawful entry into an area of the Medical Center protected by a Security Alarm System the Security Department will receive a call from SSD's Central Monitoring Station informing the Security Department of the location of the activated alarm.
3. The Security Department is the first responder to the activation of all areas of the Medical Center protected by Security Alarm Systems. Security Department personnel will respond to the location of the alarm and determine if an Unauthorized or Unlawful entry has indeed been committed of if the alarm activation was accidental or a system malfunction. Security Department personnel will respond to the alarm in accordance with all applicable Security Department Policies. If necessary Security Department personnel will summon the San Diego Sheriffs Department or the Oceanside Police Department for assistance depending on the location of the alarm activation.

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

1. Security **Alarm** and Panic Alarm Locations

Tri-City Medical Center
Security Department

Security Alarm / Panic Alarm System Locations

Panic Alarms:

Emergency Department Triage Station (2)
(Where nurse is stationed and where registration is stationed)

Emergency Department Registration Area (10)
(Supervisor Office by Door / Registration Desks / Back Wall)

Work Partners Registration Area (1)
(On the wall between the windows)

Reception/Information Desk (2)
(Under both sides of the desk)

Main Registration (8)
(Under all Desks / Back Wall / Back Work Area)

Patient Representative (2)
(Under both desks)

Cashier (3)
(Under all three desks)

Cafeteria (3)
(Under both registers / Grill)

Human Resources (2)
(Under Front Desk at Personnel and HR Offices/Both Sides)

Payroll (2)
(Under Front Window / Under Right Desk)

Pharmacy (3)
(Under front Desk / Reception / Bathroom)

Pharmacy Vault (1)
(Connected to motion and door / under desk behind door)

Staffing Office (2)
(Admin Assistant Desk / Under Staffing Desk)

Administration (4)
(Under Assistant's Desks / CNE/COO Desk)

Medical Records (1)
(Under front Desk)

Gift Shop (1)
(Under front Desk)

Maternal Child Health (2)
(Under front Desk / Nursery #2 on Viewing Window Wall)

Tri-City Medical Center
Security Department

Security Alarm / Panic Alarm System Locations

Security Alarm Systems:

Open MRI / Nuclear Medicine
2095 West Vista Way, Suite 111
Staff Code: 1397
Security Code: 5397

Home Health Care
2095 West Vista Way, Suite 212 & 219 & 220
Staff Code:
Security Code: 5397

Outpatient Lab Services
2095 West Vista Way, Suite 107
Staff Code: 13975
Security Code: 13975

Outpatient X-Ray Services
2095 West Vista Way, Suite 101
Staff Code: 2684
Security Code: 5397

Outpatient Rehabilitation Services
161 Thunder Drive
Staff Code: 13975
Security Code: 5397

Administration
4002 West Vista Way, Administration (Main Building)
Staff Code: Last 4 SSN
Security Code: 5721

Business and Management Services (BAMS)
4002 West Vista Way, BAMS
Staff Code: 13975
Security Code: 13975
CMD-51 :89632-1 (Unlock Magnet Lock)

Child Study Center
6949 El Camino Real
Staff Code: 6842
Security Code: 5397

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 08/97 **SUBJECT:** Security Department Very Important Person (VIP) Policy

REVIEWED DATE(S): 05/03, 11/06, 05/09, 07/11, ~~07/15~~ **POLICY NUMBER: 235**
REVISION DATE(S): 07/03, 06/09, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval):	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**
1. To establish guidelines to assist Security Department personnel with the effective and efficient handling of VIP persons entering the Medical Center seeking medical treatment.

B. **POLICY:**
1. The "Very Important Patient" (VIP) policy has been established to expedite the handling of those classification persons entering the Medical Center for medical treatment.

C. **PROCEDURE:**
1. The Security Officer responsible for the area that a VIP Patient will be admitted to will immediately respond to that location and check in with the person in charge of that area.
2. The responding Security Officer will be responsible for notifying the Security Manager, Supervisor, or Shift Lead Officer of the VIP Patient's location within the Medical Center. The Security Manager, Supervisor, or Shift Lead Officer will be responsible for notifying the Director of Safety of the VIP Patient's location. The Director of Safety will notify the Chief Operating Officer and the Chief Nurse Executive of the VIP's location, and an appropriate area will be discussed to relocate the VIP to ensure privacy measures are implemented.
3. The responding Security Officer, Security Manager, Supervisor, or Shift Lead Officer will insure that all applicable Administrative and Patient Care Policies regarding VIP Patients are followed.

D. **RELATED DOCUMENTS:**
1. Patient Care Services Policy ~~(formerly #374)~~: Unidentified or Confidential Patient
2. Administrative Policy ~~#524~~:: Disclosure of Information to Public and Media **524**
3. Administrative Policy ~~#526~~:: Rights to Request Privacy for Protected Health Information **526**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 05/94 **SUBJECT: Security Incident Notification**

REVIEWED DATE(S): 01/97, 05/03, 11/06, 03/09, 06/11, ~~07/15~~ **POLICY NUMBER: 208**
REVISION DATE(S): 07/03, 09/15

Department Approval: ~~07/15~~05/20
Environmental Health and Safety Committee Approval: ~~08/15~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: ~~09/15~~ n/a
Board of Directors Approval: 09/15

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel for the proper Incident Notification whenever a Security Incident occurs.

B. **POLICY:**
1. It is the responsibility of all Security Officers to properly notify the appropriate individuals whenever a Security Incident occurs. Reference Administrative Policy #234 Security Department Incident Notification.

C. **PROCEDURE:**
1. Security Department personnel are required to notify the Security Manager, Supervisor, , or Shift Lead Officer anytime a Security Incident occurs on the Medical Center campus.
2. The following is a list of Serious Security Incidents that would require the immediate Security Department Incident Notification to be executed including but not limited to:
   a. Armed and Strong Armed Robbery.
   b. Homicide or Suspected Homicide.
   c. Kidnap or Suspected Kidnap.
   d. Rape.
   e. Serious Assault or Battery.
   f. Theft of Narcotics.
   g. Any Arrest made by or to a Security Officer.
   h. Natural Disaster.
   i. Fire.
   j. Flood.
   k. Any Incident involving a Medical Center employee and requiring an immediate follow up investigation by the Security Manager, Supervisor, or Shift Lead Officer.
   l. Death or Serious Injury to any Visitor or Staff Member.
   m. Removing a Parked Vehicle from the Medical Center.
3. All notifications will be properly documented, in detail, on the Security Officer's DSR, including the time and type of contact.
4. Once the Security Manager, Supervisor, or Shift Lead Officer has been notified they will make the proper notifications to any appropriate Administrative or Medical Center personnel.

D. **RELATED DOCUMENTS:**
1. Administrative Policy #234: Security Department Incident Notification

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINITRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2003~~ ~~Reviewed: 11/06, 3/09, 6/11~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Security Management Plan~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 501~~

ISSUE DATE: 05/03~~May 05, 2003~~ **SUBJECT: Security Management Plan**

REVIEW~~ED~~ DATE~~(S)~~: 11/06, 03/09, 06/11 **POLICY NUMBER: 501**
REVISION DATE~~(S)~~:

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department personnel to utilize in the performance of their assigned duties in relation to the Medical Center Security Management Plan.

B. **POLICY:**
1. Security Department personnel are to be familiar with the Security Management Plan and the Security Department's responsibilities for Tri-City Medical Center in order to ensure a safe patient care environment and provide for the Safety, Security, and Welfare of all Patient, Visitors, and Staff Members.

C. **PROCEDURE:**
1. All Security Department personnel are to be familiar with the Security Management Plan for Tri-City Medical Center.
2. All Security Department personnel are to be familiar with the Security Departments Responsibilities and Authority associated with the Security Management Plan for the Medical Center.
3. Each Security Officer will be responsible for demonstrating proficiency in the responsibilities of the Security Department outlined in the Security Management Plan for the Medical Center.

D. **RELATED DOCUMENT(S)~~ATTACHMENT~~:**
1. **Environment of Care Policy:** Security Management Plan

1.0 PURPOSE:

~~Tri-City Medical Center is committed to protecting the personnel and property rights of patients, visitors, members of the medical staff, and employees. To maintain a program of high quality health care, it is essential that the property of the Medical Center be protected from damage, defacement and theft. All employees are responsible for making the facilities safe and secure for those who use them. (See AP&P 305, 436 and 463)~~

~~2.0 PURPOSE:~~

~~2.1 The Director of Engineering and The Environment of Care/Safety Officer have been given the authority by Administration to take action when a condition exists that could result in personal injury to individuals or damage to equipment or buildings. The Security Supervisor is responsible for the daily management of the Security Department, and is a member of the Tri-City Medical Center Security Management Committee. The Security Supervisor attends monthly meetings and submits monthly reports that identify all related security activities of the previous month, and makes recommendations for improvements. Adverse outcomes are reported through the Security Incident Notification Form and routed to the Director's of Engineering, Risk Management, and Quality Systems Improvement.~~

~~2.2 Organization-wide and Security Department specific policies and procedures are in place and have the support of the Environment of Care Committee and Administration.~~

~~3.0 PROCEDURE:~~

~~3.1 All employees have the responsibility to maintain a workplace free from acts and threats of violence.~~

~~3.1.1 All personnel must refrain from engaging in acts or threats of violence and are responsible for maintaining a work environment free from acts or threats of violence.~~

~~3.1.2 The Environment of Care Committee is responsible for overseeing the implementation and maintenance of Tri-City Medical Center's security management program and the workplace violence prevention plan. The Environment of Care Committee members include all levels of management and non-supervisory employees who have a primary responsibility for the safety, health, and well being of patients, visitors, and staff members.~~

~~3.1.3 The Environment of Care/Safety Officer serves as the Chairperson of the Environment of Care Committee.~~

Department Revision	Environmental Health and Safety Committee	Administration	Professional Affairs Committee	Board of Directors
05/20	08/20		n/a	

3.2 The Environment of Care Committee chairperson's responsibilities pertaining to workplace violence are:

3.2.1 Tracking and Trending past incidents of violence at Tri-City Medical Center.

3.2.2 Reviewing Tri-City Medical Center's current readiness to respond to issues of workplace violence.

3.2.3 Supporting training of appropriate personnel regarding issues of workplace violence.

3.2.4 Overseeing the establishment of a liaison with local police departments and other emergency services.

3.2.5 Establishing and maintaining policies and procedures for dealing with issues of workplace violence.

3.3 The Environment of Care Committee will oversee delegations of these tasks to other individuals within the Medical Center

3.3.1 The Environment of Care Committee remains responsible for the implementation and maintenance of the Medical Center's workplace violence prevention plan.

3.4 Director's Duties Regarding Workplace Violence are:

3.4.1 Provide new employee orientation to the Medical Center's Security policies, procedures and work practices.

3.4.2 Annual review of the Security Plan to address department specific aspects of workplace security issues.

3.4.3 Post or distribute workplace security information.

3.4.4 Provide a system for employees to inform management about workplace security hazards or threats of violence.

3.4.5 Provide protection of employees who report threats from retaliation by the person making the threats.

3.4.6 Ensure timely notification of the Security Department of any condition or situation, which could jeopardize the safety, security, and welfare of any employee, patient or visitor.

3.4.7 Request assistance from Security Department with these duties as needed.

3.5 Employees duties regarding workplace violence are:

3.5.1 Adhere to all Administrative and/or Department specific policies and procedures, rules, regulations and reporting requirements pertaining to workplace violence.

3.5.2 Notify supervisor and/or the Security Department immediately of any condition or situation, which could jeopardize the safety, security or welfare of any employee patient or visitor.

3.5.3 An increased security awareness and continual practice of personal safety procedures while on the Medical Center campus or while conducting duties or activities within the community.

3.5.4 Comply with procedure for all Medical Center emergency codes, policies, procedures, protocols and panic buttons or alarms.

3.5.5 Utilize the Security Department's escort service or the "buddy system" when leaving the facility and walking to their parked vehicle in the evening or nighttime hours.

3.5.6 Control access to the workplace and freedom of movement within it, consistent with the Medical Center business practices.

3.5.7 Adhere to Administrative Policy #436 regarding Employee Identification.

3.6 Work-place violence reporting responsibilities:

3.6.1 All employees are required to report immediately any acts or threats of violence, occurring on the Medical Center premises to their supervisor. No employee will be disciplined or discharged for reporting any threats or acts of violence. In addition, employees will be responsible to ensure that all departmental or Medical Center reporting policies are completed in the prescribed manner.

3.6.2 All supervisors are required to immediately report any acts or threats of violence to their director or Security Department. Supervisors are also required to report the occurrences of any warning sign of violence they observe.

3.6.3 The Human Resources Department will be consulted and assist, as needed, with all employee disciplinary and discharge policies and procedures.

3.6.4 Risk Management and Legal Services will be immediately notified, through the proper reporting mechanism, of any condition or situation, which addresses the quality of service to any Medical Center patient.

3.6.4.1 It will the responsibility of Risk Management and Legal Services Department to coordinate and supervise all mandated patient reporting policies or procedures.

3.7 Investigation of incidents of work-place violence:

~~3.7.1 The Security Department will be responsible for responding to any reported act or threat of work place violence. Additionally, the Security Department will be responsible for the appropriate documentation of all incidents.~~

~~3.7.2 The Security Supervisor will be responsible for conducting any follow up investigation and the preparation of all investigative documentation. This investigation will include, but is not limited to:~~

~~3.7.2.1 Reviewing all submitted reports.~~
~~3.7.2.2 Reviewing all previous incidents.~~
~~3.7.2.3 Visiting the scene of an incident as soon as possible.~~
~~3.7.2.4 Interviewing threatened or injured employees and witnesses.~~
~~3.7.2.5 Examining the workplace for security risk factors associated with the incident, including any previous reports of inappropriate behavior by the perpetrator.~~
~~3.7.2.6 Determining the cause of the incident.~~
~~3.7.2.7 Recommending corrective actions to prevent the incident from recurring.~~
~~3.7.2.8 Recording the findings and corrective actions taken.~~

~~3.7.3 The Security Supervisor will ensure that documentation is disseminated to all appropriate administrative or management personnel and that the mandatory reporting of all incidents is done in the appropriate time frame.~~

~~3.7.4 The Security Supervisor will be responsible for the maintaining of all investigative documentation for a five (5) year period.~~

~~3.7.5 The Security Supervisor will prepare a monthly risk assessment report and present it to the Security Management Committee for review and follow up. This report will detail all reported incidents and issues affecting the safety, security and welfare of employees, patients and visitors.~~

~~3.7.6 The Security Supervisor will ensure that the Human Resources Department is continually updated if the investigation involves an employee of the Medical Center. Risk Management, Legal Services will be updated if the investigation involves any patient at the Medical Center.~~

~~3.7.7 The Security Supervisor will assign standby security personnel for employee disciplinary and/or discharge procedures as required (i.e. the employee has been involved in prior violent acts, expressed threats of physical violence, expressed verbal abuse, or displayed signs of stress, strain or pressure in the workplace).~~

~~3.7.8 With the approval of the Director of Engineering or The Environment of Care/Safety Officer, the Security Supervisor will be responsible for notifying and interacting with local, city, county, state and federal law enforcement agencies when their assistance is required. (The exception is when the notification would possibly compromise patient confidentiality.)~~

4.0 SECURITY SENSITIVE AREAS

4.1 The following areas have been identified as high risk security areas and have department specific security policies.

4.1.1 Emergency Department
4.1.2 Behavioral Health
4.1.3 Maternal Child Health Units
4.1.4 Neonatal Intensive Care Unit
4.1.5 Pharmacy Department
4.1.6 Human Resources Department
4.1.7 Adult Critical Care Unit
4.1.8 Information Technology

4.2 These policies will be reviewed by the Department Director, Security Department Supervisor and the Environment of Care Committee on an annual basis.

4.3 The Security Department has developed and does provide annual specialized security training to staff of all high risk security areas.

4.4 The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:

4.4.1 Emergency Department:

4.4.1.1 Electronic access control;
4.4.1.2 Panic buttons;
4.4.1.3 CCTV camera

4.4.2 Behavioral Health: Electronic access control
4.4.3 Maternal Child Health Units:

4.4.3.1 Electronic access control;
4.4.3.2 CCTV;
4.4.3.3 Department policy in place for identifying visitors;
4.4.3.4 Department procedure for uniquely identifying mother-infant units
4.4.3.5 Teaching program for parents to explain the security process

4.4.4 Neonatal Intensive Care Unit: Electronic access control
4.4.5 Pharmacy Department:

4.4.5.1 Electronic access control

~~4.4.5.2 Infrared Security System~~

~~4.4.6 Business Office:~~

~~4.4.6.1 Electronic access control~~
~~4.4.6.2 Panic button~~

~~4.4.7 Human Resources department: Panic buttons (benefits, reception)~~
~~4.4.8 Adult Critical Care Unit: Electronic access control~~

~~4.4.9 Patient Representative Office Panic Button~~

~~5.0 PROACTIVE SECURITY MEASURE:~~

~~5.1 The Security Department will be responsible for enacting proactive security measures as follows:~~

~~5.1.1 Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/accidents.~~
~~5.1.2 Locking/unlocking of exterior doors, departments, and associated rooms; on-going inspecting of all sensitive areas throughout the Medical Center.~~
~~5.1.3 Ensuring that all employees properly display their photographic identification badges at all times.~~
~~5.1.4 Submitting reports to the Director of Engineering pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.~~
~~5.1.5 Providing unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department and the Women's Resource Center. Security will also ensure that there is a lot or location reserved for long-term vehicle parking.~~
~~5.1.6 Monitoring the Security Department Closed Circuit Television System (CCTV).~~
~~5.1.7 Providing campus escort services 24 hours per day for employees and visitors.~~

~~6.0 REACTIVE SECURITY MEASURES~~

~~6.1 These measures are to be implemented by the Security Department:~~

~~6.1.1 Timely completion of departmental reports of theft.~~
~~6.1.2 Assistance of patients, visitors and employees with reporting of crimes to the appropriate law enforcement agency.~~
~~6.1.3 Response to alarm/panic button activations both on-site and off-site.~~
~~6.1.4 In addition, Individual Department Director's or their designee will~~

conduct in-service training of newly hired employees in proper alarm activation, and departmental security procedures.

7.0 AGGRESSIVE RESPONSE TRAINING:

7.1 Tri-City Medical Center has elected to implement the Techniques for Effective Aggressive **Management** (T.E.A.M.) format for the mandated training of staff in compliance with the California Health and Safety Code Section 1247.7 and 1257.8. This training includes:

7.1.1 General safety measures.
7.1.2 Personal safety measures.
7.1.3 The assault cycle.
7.1.4 Aggression and violence predicting factors.
7.1.5 Characteristics of aggressive and violent patients and victims.
7.1.6 Verbal and physical maneuvers to diffuse and avoid violent behavior.
7.1.7 Strategies to avoid physical harm.
7.1.8 Restraining techniques.
7.1.9 Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).

7.2 A condensed version of the T.E.A.M. format will be offered to ancillary staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.

7.3 The Security Department, Education Department, and the Environment of Care/Safety Officer will develop a self learning packet and competency assessment to comply with the annual update for all appropriate staff. This will ensure quality, continuity, consistency and evaluation.

7.4 The Security Department will assist, as needed, in developing training and instruction on general and job-specific workplace security practices for all employees.

7.4.1 Training and instruction will be provided when the Security Plan is first established and appropriately thereafter.

7.4.2 Training will also be provided to all employees and to other employees for whom training has not previously been provided and to all employees, supervisors and managers given new job assignments for which specific workplace security training is required.
7.4.3 Additional training and instruction will be provided to all personnel whenever new or previously unrecognized security hazards are identified.

7.5 Security Department personnel will be responsible for implementing and monitoring all appropriate administrative or department specific policies, procedures and protocols pertaining to

~~the following situations:~~

~~7.5.1 The receiving of a VIP patient.~~

~~7.5.2 The utilization of non-Security Department personnel to assist in the controlling of all vehicular and pedestrian traffic within the Medical Center campus in the event of a disaster or civil disturbance.~~

~~7.6 The Security Committee Chairperson will be responsible for submitting to the Environment of Care Committee an annual evaluation of the Security Management Plan focusing on:~~

~~7.6.1 Objectives~~
~~7.6.2 Scope~~
~~7.6.3 Performance~~
~~7.6.4 Effectiveness~~

~~7.7 The Security Department will conduct an annual training program for Security staff in the proper process of reporting patient related incidents.~~

~~8.0 SECURITY STAFFING~~

~~8.1 The Security Department will provide service 24 hours a day, 7 days per week coverage of the Medical Center.~~

~~8.2 Staffing will consist of one (1) Security Supervisor, one (1) Security Officer assigned to the east side of the campus and one (1) Security Officer assigned to the interior of the hospital.~~

~~8.3 Within the Security Department, a pool of trained per diem Security Officers will be utilized to cover staffing vacancies.~~

~~8.4 In the event of a critical workplace violent incident or situation, the Security Department will supplement the current staffing levels with contractual security personnel.~~

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

Delete – Combined with Security Policy 111: Security Department Reports

SUBJECT: Security Officer Documentation

ISSUE DATE:	**05/12**	**POLICY NUMBER: 238**
REVIEWED DATE(S):	**07/15**	
REVISION DATE(S):	**09/15**	

Department Approval Date(s):	~~07/15~~**05/20**
Environmental Health and Safety Committee Approval Date(s):	~~08/15~~**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval Date(s):	~~09/15~~ **n/a**
Board of Directors Approval Date(s):	**09/15**

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

~~1. To develop uniform documentation requirements for all Safety and Security related events.~~

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

~~1. All TCMC Security Officers are required to submit appropriate documentation. Security documentation includes the following: DSR's, Incident Reports, Enforcement Reports, Missing Patient Checklists and any other equipment or detail log. All Security officer field notes are to be destroyed upon submission of reports and documents.~~

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

~~1. DSR (Daily Security Report)~~

~~a. The Officer's DSR needs to be completed at the end of the Officer's shift. The DSR is to be chronological with accurate times and complete details of all the Officer's activities for that day. This information will include times spent in each location, and every assignment the Officer completes. All room numbers, points of contact, employee and patient names are to be included. In addition, if the officer has any involvement with lost and found or control of another person's belongings, the contents and the disposition will be documented as well as any bag, name or identification number. DSR's are not to be used in lieu of an Incident Report unless directed by the Security Supervisor, Shift Lead, or designee. If the Security Officer is assisting another officer, he will still include all details in his own DSR as if he were the Primary Officer involved.~~

~~2. Crime / Incident Reports~~

~~a. Crime / Incident Reports need to be completed (draft) within the first 24 hours of the incident, with final copy within 48 hours. All fields (boxes) need to be completely filled out with the proper information unless the information is not applicable in which N/A will be used. All known and investigated information will be included in the narrative section utilizing the questions (who, what, when, where, why and how) with full attention to detail, accuracy, consistency, and format. All appropriate attachments are to be included behind the narrative portion of the report (picture and video attachment sheets, witness statements, driver license and insurance information). All points of contact will be identified with title, name, department, phone numbers and their relation to the incident. A report will be generated for all risk management or liability issues regardless of the level of cooperation from witnesses or complainants. The final decision will be at the discretion of the Security Supervisor, Shift Lead, or designee.~~

3. Enforcement Reports
   a. Enforcement Reports need to be written with attention to filling out all the details (patient name, time 5150 was written or discontinued, whether restraints were used and at what time, all parties involved (Police Officer, Doctor, Nurse, Behavioral Health Liaison), and a synopsis written for each major Security intervention or event. (Not to include any medical procedure or non-security related event). Each detail will have a new entry added to the narrative.
4. Missing Patient Checklist
   a. A missing patient checklist will be utilized any time a patient is known to be missing from the unit. The checklist locations will be divided up by the available officers, and every area of the hospital will be searched as per the form. The original form with the areas checked by each officer will be placed in the "Submitted Reports" box, and a copy will be placed on the back of the Officer's DSR.
5. Equipment and Detail Logs
   a. The Security Department Equipment and Detail Logs need to be updated and completed by the end of the officer's shift. These logs include: Cart Maintenance Log, Crime / Incident Report Log, Fire Safety Check, Flashlight Log, Floor Check Log, Main Lobby Post Log, Risk Management Log, Safety Infractions and Work Order Log. Accurate times and complete details are to be denoted in the logbooks.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 01/03 **SUBJECT:** Security Panic Alarm System Response

REVIEWED DATE(S): 05/03, 11/03, 11/06, 03/09, ~~6/11, 07/15~~ 06/11 **POLICY NUMBER: 221**
REVISION DATE(S): 07/03, 11/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. In an ongoing effort to provide a safe working environment to ensure the best possible patient care for the patients of the Medical Center the Security Department continually evaluates all areas of the Medical Center to determine if an area is deemed a high-risk area.

B. **POLICY:**

1. The Security Department has established a Panic Alarm system with activation switches in areas of the Medical Center that are determined to be a high-risk area.

C. **PROCEDURE:**

1. Each Security Officer is responsible for knowing the location of each Panic Alarm location within the Medical Center and at all off site locations.
2. Attached is a list of all Panic Alarm location within the Medical Center and all off site locations with Panic Alarm activation switches.
3. When a Panic Alarm is activated an alarm will sound in the PBX/Operator Office indicating which location has activated the alarm. The PBX Operator will call the On-Duty Security Department personnel and inform them of silent alarm activation at location _____.
4. All On-Duty Security Department personnel will respond to the location of the activated alarm, assess the situation, and take the necessary action in accordance with Medical Center and Security Department policies.

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

1. Security **Alarm** and Panic Alarm Locations

Tri-City Medical Center
Security Department

Security Alarm / Panic Alarm System Locations

Panic Alarms:

Emergency Department Triage Station (2)
(Where nurse is stationed and where registration is stationed)

Emergency Department Registration Area (10)
(Supervisor Office by Door / Registration Desks / Back Wall)

Work Partners Registration Area (1)
(On the wall between the windows)

Reception/Information Desk (2)
(Under both sides of the desk)

Main Registration (8)
(Under all Desks / Back Wall / Back Work Area)

Patient Representative (2)
(Under both desks)

Cashier (3)
(Under all three desks)

Cafeteria (3)
(Under both registers / Grill)

Human Resources (2)
(Under Front Desk at Personnel and HR Offices/Both Sides)

Payroll (2)
(Under Front Window / Under Right Desk)

Pharmacy (3)
(Under front Desk / Reception / Bathroom)

Pharmacy Vault (1)
(Connected to motion and door / under desk behind door)

Staffing Office (2)
(Admin Assistant Desk / Under Staffing Desk)

Administration (4)
(Under Assistant's Desks / CNE/COO Desk)

Medical Records (1)
(Under front Desk)

Gift Shop (1)
(Under front Desk)

Maternal Child Health (2)
(Under front Desk / Nursery #2 on Viewing Window Wall)

Tri-City Medical Center
Security Department

Security Alarm / Panic Alarm System Locations

Security Alarm Systems:

Open MRI / Nuclear Medicine
2095 West Vista Way, Suite 111
Staff Code: 1397
Security Code: 5397

Home Health Care
2095 West Vista Way, Suite 212 & 219 & 220
Staff Code:
Security Code: 5397

Outpatient Lab Services
2095 West Vista Way, Suite 107
Staff Code: 13975
Security Code: 13975

Outpatient X-Ray Services
2095 West Vista Way, Suite 101
Staff Code: 2684
Security Code: 5397

Outpatient Rehabilitation Services
161 Thunder Drive
Staff Code: 13975
Security Code: 5397

Administration
4002 West Vista Way, Administration (Main Building)
Staff Code: Last 4 SSN
Security Code: 5721

Business and Management Services (BAMS)
4002 West Vista Way, BAMS
Staff Code: 13975
Security Code: 13975
CMD-51 :89632-1 (Unlock Magnet Lock)

Child Study Center
6949 El Camino Real
Staff Code: 6842
Security Code: 5397

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 23, 1991~~ ~~Reviewed: 5/95, 1/97, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Protocol when interacting with Medical Center Patients~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 211~~

ISSUE DATE: **04/20~~April 23, 1991~~**

SUBJECT: **Security Protocol ~~when interacting with Medical Center~~ for Patients Interaction**

REVIEW~~ED~~ DATE~~(S)~~: **05/95, 01/97, 12/01, 05/03, 11/06, 03/09, 06/11, 05/13**

POLICY NUMBER: 211

REVISION DATE~~(S)~~: **12/01, 07/03**

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide general standards of conduct when Security Officers interact with any Medical Center patients.

B. **POLICY:**
1. The following procedure will summarize the Standard of Conduct all Security Officers will utilize when, during the course of their duties, they must interact with Medical Center patients.

C. **PROCEDURE:**
1. At all times, Security Officers will conduct themselves in a professional manner and ensure that the patient's safety and welfare is maintained.
2. At no time will any Security Officer enter into any patient's room, unless in the company of a medical staff member. If a patient requests the Officer for any assistance, the Officer will immediately notify a member of the medical staff.
3. If any Officer feels it necessary to check on the welfare of any patient, the Officer will only stand in the room doorway and make the necessary observation. If it appears that the patient is having some type of difficulty, the Officer will immediately notify a member of the medical staff.
4. At no time will any Officer, acting on the request of any medical staff employee perform any medical type activity with any patient. This includes but is not limited to checking the patient's IV flow, breathing, tightness of any applied restraints, welfare, or any other reason.
5. At no time will any officer transport via gurney or wheelchair any patient from one department to another department without the assistance of a medical staff member.

6. At no time will any Officer, for any reason, place themselves in a one-on-one position, where they could be accused of any impropriety.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 04/96

SUBJECT: Security Sensitive Areas

REVIEWED DATE(S): 02/97, 05/03, 11/06, 03/09, 06/11, 07/15

POLICY NUMBER: 502

REVISION DATE(S): 02/97, 07/03, 09/15

Department Approval:	07/15 05/20
Environmental Health and Safety Committee Approval:	08/15 08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	09/15 n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To provide for the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members of Security Sensitive Areas.

B. **POLICY:**

1. It is the goal of this policy to be proactive and not reactive in the Security Management for all Security Sensitive Areas of Tri-City Medical Center. By the nature of their existence, the areas listed below are considered to be Security Sensitive Areas. The patients contained within each of the Security Sensitive Area units, as a result of their condition, are totally dependent upon the staff working within these units. This dependency is illustrated through constant one-on-one care being administered. The clinical staff is normally considered the first line of defense, however should a situation occur where a Patient, Visitor, or Staff Member has been victimized, threatened, or injured, Security assistance should be requested immediately by calling the Medical Center Code Phone by dialing "66".

C. **PROCEDURE:**

1. The Security Department working with the Environmental Health and Safety Committee have identified the following Medical Center departments, Security Sensitive.
   a. Emergency Department (ED)
   b. Behavioral Health Unit (BHU)
   c. Women and Newborn Services (WNS)
   d. Intensive Care Unit (ICU)
   e. Pharmacy Department
   f. Business Office (PFS / BAMS)
   g. Human Resources Department (HRD)
   h. Neonatal Intensive Care Unit (NICU)
   i. Medical Records Department
   j. Information Technology Departments (I.T.)
   k. Nuclear Medicine or Hot Lab
   l. Central Plant infrastructure
   m. Forensics Services [Out and In-Patient]
   n. Administration Department
   o. Risk Management/ Regulatory
   p. Closed Units

2. The department staff of each of these areas is charged with the responsibility of providing the initial line of safety for their patients or staff members, the Security Department will provide back up as requested unless the Security Supervisor, designee, or Shift Lead Officer feels that a Security Intervention is required to provide for the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members.
3. The typical situations that could occur include but not limited to the following:
    a. Disruptive Patient, Visitor, or Staff Member.
    b. Visitor Control Issue.
    c. Child Custody Issue
    d. Criminal Activity
        i. Theft
        ii. Trespass
        iii. Assault
        iv. Battery
    e. Emergency Situation
    f. Emergency Preparedness
4. In any of the above situations if it can not be controlled or resolved by appropriate staff member then the Security Department should be immediately notified by utilizing the Code Phone by dialing "66" and following the procedures outlined in Administrative Policy #221 related to reporting a Dr. Strong.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

ISSUE DATE: 09/91 **SUBJECT: Security Vehicles**

REVIEW~~ED~~ DATE~~(S)~~: 06/94, 10/97, 05/03, 11/06, 03/09, 06/11~~, 07/15~~ **POLICY NUMBER: 405**
REVISION DATE~~(S)~~: 7/03, 09/15

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**
1. To establish a uniform procedure for the use of the Security Vehicles by Security Department personnel

B. **POLICY:**
1. It is the policy of the Security Department to maintain and supply Security Vehicles for the use by all Security Department personnel in the course of their assigned duties. In order to maintain these vehicles in proper working order, it will be the responsibility of each Security Officer to follow the established procedures.

C. **PROCEDURE:**
1. All Security Officers will be able to demonstrate their proficiency in the proper operation of all Security Vehicles.
2. Prior to the use of any Security Vehicle it will be the responsibility of each Officer to ensure that the Vehicle is in proper working order.
3. Any conditions that may contribute to the failure of the vehicle or any unsafe or unsatisfactory conditions will be reported to the Security Manager or Designee immediately in order to call the appropriate company for any necessary repairs.
4. Eating will not be permitted in any security vehicle. Drinks may be stored in a vehicle, and any spills will be immediately cleaned up. Each Officer is responsible for keeping all Vehicles in a Safe and Clean working order.
5. All Security Department personnel utilizing any Vehicle will operate the Vehicle in a Safe and Proper manner, observing all Medical Center and Traffic rules and regulations.
6. Security Carts are not permitted off property unless authorized by Shift Lead or Security Manager.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 20, 1993~~ ~~Reviewed: 4/94, 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Seized Contraband or Evidence~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 231~~

ISSUE DATE: 03/20~~March 20, 1993~~ **SUBJECT:** **Seized Contraband or Evidence**

REVIEW~~ED~~ DATE~~(S)~~: 04/94, 10/97, 05/03, 11/06, 03/09, 06/11 **POLICY NUMBER: 231**

REVISION DATE~~(S)~~: 07/03

Department Approval: ~~07/15~~05/20
Environmental Health and Safety Committee Approval: ~~08/15~~08/20
Administration Approval: 10/20
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

A. **PURPOSE:**
1. To establish a set of guidelines for Security Department personnel to utilize in the proper handling of seized contraband or evidence by Security Officers

B. **POLICY:**
1. To ensure that the proper chain of custody for all contraband or evidence seized by a Security Officer in the performance of their assigned duties. Reference Administrative Policy#315 **Patients Injured by a Deadly Weapon or Criminal Act, Proper** Handling of Evidence

C. **PROCEDURE:**
1. Upon receipt of any item seized **or received** as contraband or evidence, the receiving Security Officer will ensure that the item is placed in a protective covering.
2. The Security Officer will record the following information for future reference.
   a. The Date and Time the property was received.
   b. A description including Name, Address, Phone Number, Clothing Description, and any other information regarding the person the property was seized from.
   c. A chronological account of the factors~~,~~ which lead to the seizure.
   d. The complete name and identification number of the receiving Law Enforcement Officer. In addition, the date, time and location of the transfer will be noted **[i.e. notify the local law enforcement office and ask for an incident / case number]**.
   ~~d.~~**e. A photograph will be collected of all such evidence and for documentation purposes only.**
3. All the above information will be placed on a Security Department ~~Incident~~ Report **[D.S.R. or incident as per Supervisor]** as per the current departmental reporting format. This report will be completed and turned in for approval at the end of the Officer's assigned shift.

4. All seized items will remain in the Security Officer's personal possession~~,~~ until such time as the item is either properly secured or transferred to the responding Law Enforcement Officer.

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

1. Administrative Policy ~~#315~~: **Patients Injured by a Deadly Weapon or Criminal Act, Proper Handling of Evidence**

Tri-City Medical Center
Oceanside, California

DELETE - Combined with Security Policy: Post Positions #202

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 11, 1994~~ ~~Reviewed: 1/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Shift Posts area of Responsibility~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 203~~

ISSUE DATE: 05/94~~May 11, 1994~~

SUBJECT: Shift Posts area of Responsibility

REVIEWED DATE(~~S~~): 01/97, 05/03, 11/06, 03/09, 06/11, 05/13

POLICY NUMBER: 203

REVISION DATE(~~S~~): 7/03

Department Approval Date(s):	05/20
Environmental Health and Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval Date(s):	n/a
Board of Directors Approval Date(s):	

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

~~1. To assist in defining specific areas of responsibility for Security Department shift Post Positions.~~

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

~~1. It is the policy of the Security Department that each Post Position will have clearly defined areas of responsibility for all required or assigned security activities or duties.~~

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

~~1. All Security Officers are expected to actively patrol all areas of the Medical Center regardless of what post they are assigned to in the Security Department. While assigned to a particular post, that Officer will be responsible for the areas of responsibility associated with that post.~~

~~2. Areas of responsibility for each assigned Security Officer are based on either a 1-Post, 2-Post, 3-Post, 4-Post, or 5-Post assignment. Areas of responsibility are as follows.~~

~~a. The 1-Post is responsible for the West Side of the Medical Center.~~

~~b. The 2-Post is responsible for the East Side of the Medical Center.~~

~~c. The 3-Post is responsible for the Emergency Department, Mental Health Unit, and Ancillary Building areas.~~

~~d. The 4-Post is a split shift post position and is responsible for specific assigned duties from each Shift Lead Officer for all areas of coverage.~~

~~e. The 5-Post is a split shift post position and is responsible for specific assigned duties from each Shift Lead Officer for all areas of coverage.~~

~~3. It will be the responsibility of each Officer assigned to their post to respond for requests for service for their assigned area of responsibility. If for any reason the Officer assigned to a~~

~~post is unable to answer a call for assistance for their assigned area of responsibility it will be the responsibility of that Officer to request assistance from another Officer on their shift.~~

~~4. The Security Supervisor, Designee, or Shift Lead Officer is responsible for ensuring that each Shift Post Officer responds to their area of responsibility for any requested services. The Security Supervisor, Designee, or Shift Lead Officer may also re-assign assignments to other Shift Officer as needed.~~

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

DELETE – Combined with Security Policy: Work Overtime 106

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 23, 1991~~ ~~Reviewed: 5/94, 10/97, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 7/03, 1/11~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Shift Schedule~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM – # 201~~

SUBJECT: Security Department Shift Schedule

ISSUE DATE: April 23, 1991
REVIEWED DATE(S): 5/94, 10/97, 5/03, 11/06, 3/09, 6/11, 5/13
REVISION DATE(S): 7/03, 1/11

Department Approval Date(s):	**05/20**
Environmental Health and Safety Committee Approval Date (s):	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s):	

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

~~1. To Provide a fair and equitable Security Department Schedule system for the staffing of Security Officers in order to provide adequate coverage to provide for the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members to ensure the best possible healthcare possible.~~

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

~~1. It is the Policy of the Security Department to maintain adequate staffing or post assignments based on current departmental needs and budget allocations.~~

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

~~1. It is the responsibility of the Security Supervisor or Designee to staff the shift security post positions in such a manner as to ensure the Safety, Security, and Welfare of all medical center Patients, Visitors, and Staff Members.~~

~~2. If any Officer desires to change an assigned shift and/or days off it will only be approved if there is a current opening on the desired shift or days off.~~

~~3. If there are no current shift openings, a change may be made and approved if it is mutually agreed to by the requesting Officer and an Officer assigned to the desired shift. This does not preclude the Security Supervisor from implementing any changes in the shift schedule for the good of the department.~~

~~4. The Security Supervisor or designee will be responsible for posting the upcoming shift schedule, no later that one week prior to the implementation date. The schedule will be posted in the main Security Department Office for the review of all Security Officers.~~

5. The Security Department schedule may be posted at a later date than one week prior to the implementation date if there are circumstances which prevent the schedule from completion prior to the one week posting requirement.
6. Due to the available staffing or departmental needs, the occasion may arise, for changes in the posted schedule. Every effort will be made to notify any Security Officer that has been affected by any changes. It is each Officer's responsibility to review and keep updated on the current schedule
7. To ensure Shift-to-Shift pass-downs are complete and accurate, pass-downs will begin 15 minutes before the hour, and the oncoming shift will be dressed in the required Security uniform and ready to begin duties at the beginning of their shift. The Security Department Shifts are as follows:
   a. 1st shift - 05:45 hours to 14:15 hours
   b. 2nd shift -13:45 hours to 22:15 hours
   c. 3rd shift - 21:45 hours to 06:15 hours

TRI-CITY MEDICAL CENTER	POLICIES AND PROCEDURES
Formulation: March 29, 1991 Reviewed: 6/94, 12/96, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13 Revision: 12/01, 7/03 Approvals: Director of Security	Subject: Span of Control **DELETE – no longer needed** Page 1 of 1
Submitted By: Security Department	Procedure Manual: Security Department SDPPM - # 104

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**1.0 Purpose:**~~

~~To establish guidelines for determining the number of personnel one supervisor can effectively control.~~

~~**2.0 Policy:**~~

~~The principal of Span of Control will be followed by the Security Department whenever possible. Span of Control relates to the number of subordinates that a supervisor can effectively control.~~

~~**3.0 Procedure:**~~

~~Due to the nature of the duties that Security Officers must perform at the Medical Center an effective number of subordinates a supervisor can effectively supervise will vary based on the level of service needed and the available staffing.~~

~~3.1 In no case will any Supervising Officer, below the level of Security Supervisor, be responsible to supervise more than five (5) Security Officers at one time.~~

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 2, 1991~~ ~~Reviewed: 4/94, 12/96, 3/02, 11/06, 3/09, 5/13~~ ~~Revision: 3/02, 3/11, 03/12~~ ~~Approvals: Director of Security~~	~~Subject: Staff Meetings~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 105~~

ISSUE DATE: April 2, 1991

SUBJECT: ~~Staff~~ Security Department Meetings, De-Briefs, and Pass-Downs

REVIEW DATE: 04/94, 12/96, 03/02, 11/06, 03/09, 05/13

POLICY NUMBER: 105

REVISION DATE: 03/02, 03/11, 03/12~~,~~

Department Approval:	01/20
Environmental Health & Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. **Security Department** ~~Staff~~ Meetings, **etc.** not only enhance the internal flow of communication but they also assist in the updated training of all Security Departmental Personnel;~~,~~ therefore, all Department ~~Staff~~ Meetings are considered mandatory unless the officer is excused prior to the meeting by the ~~Security~~ Supervisor. These meetings can also be utilized to resolve operational problems, evaluate the effective utilization of departmental resources, and the assessment of long range and short range departmental objectives. When used properly, ~~staff~~ meetings, **etc.** can greatly increase the departments overall efficiency.

B. **POLICY:**

1. The Security Supervisor is encouraged to conduct staff meetings, **etc.** as needed **and routinely**~~.~~

C. **PROCEDURE:**

1. It is the responsibility of the Security Supervisor to assess the need, the scheduling, and the conducting of all staff meetings.
2. Assessing the need for a staff meeting can be based on the following.
   a. The need for updated training, detailed briefings on situations that affect the Medical Center, ongoing operational routines, and the solving of problems effecting the Security Department.
   b. Progressive reports ~~on,~~**of** ongoing assignments **and**~~,~~ the directing and staffing of personnel for upcoming assignments.

c. When a particular task~~,~~ affecting the Security Department~~,~~ requires the formulation of a committee, the appointment of a liaison designee or committee with other Medical Center Departments for the enhancing of an ongoing program.

3. Scheduling the staff meetings should include the following.
   a. A clearly stated purpose for the staff meeting. This statement should include the role of any departmental employee.
   b. A written agenda for all attendees.
   c. Assignments given in writing to any participating employee.
4. When scheduling, the Security Supervisor should provide the following.
   a. Sufficient time to prepare for the meeting.
   b. Sufficient time during the meeting so that all objectives can be properly covered.
   c. Prior notification to all participating employees, addressing their responsibilities in the meeting.
   d. A meeting notice specifying the time, date, location, and approximate length of time of the meeting.

~~e.~~**5. When a de-brief and / or pass-down occurs, the need for updated training, detailed briefings on situations that affect the hospital, ongoing operational routines, and the solving of problems effecting the Security Department will be the intent for initiation.**

~~f.~~**a. An incident de-brief will be completed after all sentinel events, any high-risk liability situation, and / or as the department's leadership members see fit to communicate about a future incident's expectations. De-briefs may also occur between post rotations and are important tools to communicate liability activity.**

~~g.~~**b. Pass-downs occur at the beginning and end of all Security Department shifts. Pass-downs convey to the on-coming shift activity that occurred and possible future assistance needed by the hospital; pass-downs are given by lead and relief-lead security officers. Pass-downs are to be documented by means of a report or field notes.**

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

ISSUE~~EFFECTIVE~~ DATE: 11/88 **SUBJECT:** Traffic Control in the Event of a Disaster:

REVIEW DATE: 07/90, 04/94, 11/06, 03/09, 06/11 **POLICY NUMBER:** 800
REVISION DATE: 04/91, 03/97, 05/00, 06/03, 12/05

Department Approval:	05/20
Environmental Health and Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide orderly flow of traffic to and from the medical center in the event of a disaster.

B. **PERSONNEL:**
1. Security Supervisor
2. Security Officers.
3. Other assigned personnel from the labor pool.

C. **POLICY:**
1. The Security Supervisor or his designee is responsible for establishing and maintaining traffic flow during a disaster. He may supplement their staff from the labor pool as needed.

D. **PROCEDURE:**
1. In the event of activation of the disaster plan, the following procedure will be instituted:
   a. In the event of a major disaster, traffic to and from the hospital will be strictly controlled.
      i. Security personnel will be posted at both the Vista Way and Thunder Drive entrances to the Medical Center grounds.
      ii. The Vista Way entrance will admit emergency vehicles, private vehicles (only if casualties are being transported), physicians and local agencies (police, fire departments), etc.
      iii. The entrance shall be secured with barricades and appropriate signs, tape, and traffic cones.
      iv. Hospital personnel must have proper identification to gain entrance and shall be directed to the east, or Thunder Drive entrance.
      v. Security will assure adequate personnel by requesting additional personnel from the Labor Pool. The additional designated personnel shall be properly identified with vests and flashlights.
      vi. ~~Visitors and concerned family members of casualty victims will be directed to the Child Care/Family Information (CC/FIC) at the Education Annex.~~
      vii. Security personnel will also be posted at the hospital triage area to assist in orderly flow of traffic. Traffic cones and tape will be used to cordon off this area.
      viii. Physicians will be directed to the physicians parking lot upon arrival.
2. In the event of a disaster situation, sufficient security personnel shall be posted at parking lot entrances, triage area and emergency entrances to maintain the orderly flow of traffic and emergency vehicles.

E. **AUTOMATIC REVIEW:**

1. This policy/procedure will be reviewed annually and updated as needed. It is the responsibility of the Security Supervisor to:
   a. Orient and educate the security staff to the disaster plan.
   b. Maintain an updated version of the Security Disaster plan and Call back roster.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRAT

DELETE – combined with Security Policy: Department Organization 101

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 29, 1991~~ ~~Reviewed: 5/94, 12/96, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 12/01, 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Unity of Command~~ ~~Page 1 of 2~~
~~Submitted By: Security Supervisor~~	~~Procedure Manual: Security Department SDPPM # 102~~

SUBJECT: Unity of Command

ISSUE DATE: March 29, 1991
REVIEWED DATE(S): 5/94, 12/96, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13
REVISION DATE(S): 12/01, 7/03

Department Approval:	05/20
Environmental Health & Safety Committee Approval:	08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. To establish a clear-cut line of authority in order to promote employee efficiency, responsibility, and reduce any possible confusion on the part of Security Officers~~

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

~~1. The principle of Unity of Command shall, whenever possible, be practiced in all organizational components of the Security Department.~~
~~2. The level of command will be as follows.~~
~~a. Security Supervisor~~
~~b. Lead/Charge Security Officer(s)~~
~~c. Security Officers~~

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

~~1. The concept of Unity of Command states that.~~
~~2. Every Security Officer will be accountable to only one supervisor.~~
~~3. Only one person will be in complete command of any operation or incident.~~
~~4. In case of an emergency, the Security Supervisor or his/her designee will assume the responsibility of Operation/Incident Supervisor. In the absence of the Security Supervisor, The Lead/Charge Security Officer will assume the role of Operation/Incident Supervisor and will notify the Security Supervisor of all facts involved in a timely manner. The Lead/Charge Security Officer will only relinquish his/her responsibilities if relieved by the Security Supervisor.~~
~~5. In all non-emergency situations the standard levels of command will be utilized and remain in effect.~~

6. In all of the following situations, the Lead/Charge Security Officer will immediately notify the Security Supervisor.
   a. Discovery or notification of a substantial theft of Medical Center property.
   b. Personal injury to any Medical Center staff, visitor, or patient.
   c. Discovery or notification of substantial damage sustained to any Medical Center staff, visitor, or patient's personal property.
   d. Any incidences involving an employee from another Medical Center department, which requires immediate action.
   e. Any incident, which involved the arresting of a subject.

Tri-City Medical Center
Oceanside, California

DELETE – follow Administrative Policy: Absence and Tardiness 408

SECURITY PERSONNEL

SUBJECT: Unplanned Time Off (Unscheduled Absence/Tardy)

ISSUE DATE: 04/91
REVIEWED DATE(S): 6/94, 10/97, 5/03, 11/06, 3/09, 6/11, 07/15
REVISION DATE(S): 7/03, 09/15

POLICY NUMBER: 304

Department Approval Date(s):	~~07/15~~05/20
Environmental Health and Safety Committee Approval Date(s):	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval Date(s):	09/15
Board of Directors Approval Date(s):	09/15

~~A. PURPOSE:~~

~~1. To provide a uniform procedure for unplanned time off (sick leave, absence, tardy) by Security Department personnel.~~

~~B. POLICY:~~

~~1. All Security Department personnel shall follow and be aware of the following procedure for an unplanned time off. Reference Administrative Policy #408 Absences and Tardiness~~

~~C. PROCEDURE:~~

~~1. Sick Leave~~

~~a. While it is impossible to predict illness, the fact that an employee is taking sick leave and will not be able to report to work should be conveyed by telephone to the Security Supervisor or Shift Lead Officer on-duty at least Three (3) hours prior to the beginning of the shift or the absence will be treated as an unexcused absence. An Unscheduled Absence for will be completed by the Security Supervisor or Shift Lead Officer upon receipt of the call for absence or tardy by any Officer.~~

~~b. If an employee's illness extends beyond one day, the employee must continue to ensure that notification is made of this fact on a daily basis. An unscheduled absence/tardy form will be completed by the employee receiving the call and forwarded to the Security Supervisor or Designee.~~

~~c. Any absence of three days or more due to illness will require an Employee Health or Doctor's release before an Officer may return to work. This requirement may also be applied to less that three days if the Employee Health Nurse believes it is necessary for any reason or it is determined the employee has had a documented unsatisfactory absence record.~~

~~2. Absences and Tardiness:~~

~~a. As per Administrative Policy, employees are expected to be on-duty the hours and days assigned. Employees should report promptly at their assigned starting time in order to be ready for duty at the beginning of their shift.~~

~~b. While it is impossible to predict most situations that may cause tardiness, as much advanced notification as possible needs to be conveyed, by telephone to the Security Supervisor or Shift Lead Officer and inform them of an estimated time of arrival. The Security Supervisor or Shift Lead Officer will then complete the Unscheduled Absence / Tardy form.~~

c. An employee is considered tardy when the employee reports to their work area after their regular scheduled starting time. Working late to make up for tardiness will not be authorized without prior approval of the Security Supervisor or Designee.

d. Absenteeism or Tardiness in excess of Tri-City Medical Center Administrative Policy or Security Department Policy may result in disciplinary action up to and including termination.

D. RELATED DOCUMENTS:

1. Administrative Policy #408: Absences and Tardiness

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: March 27, 1991~~ ~~Reviewed: 1/94, 11/96, 12/01, 5/03, 11/06, 3/09, 6/11, 5/13~~ ~~Revision: 1/94, 12/01, 7/03, 7/09~~ ~~Approvals: Director of Security~~	~~Subject: Use of Force~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM # 209~~

ISSUE DATE: **03/91~~March 27, 1991~~** **SUBJECT: Use of Force**

REVIEW~~ED~~ DATE~~(S)~~: **01/94, 11/96, 12/01, 05/03, 11/06, 03/09, 06/11, 05/13** **POLICY NUMBER: 209**
REVISION DATE~~(S)~~: **01/94, 12/01, 07/03, 07/09,**

Department Approval: **05/20**
Environmental Health and Safety Committee Approval: **08/20**
Administration Approval: **10/20**
Professional Affairs Committee Approval: **n/a**
Board of Directors Approval:

A. **PURPOSE:**
1. To establish guidelines as to when and how much **physical** force is to be utilized by ~~Medical Center~~ **Tri-City Healthcare District** Security Officers in the performance of ~~their~~ **specific** duties.

B. **POLICY:**
1. It is the policy of the Tri-City Medical Center Security Department that all Security Officers will utilize a standard **and**~~,~~ systematic policy for the use of force **and have been trained in Non-Violent Crisis Intervention [N.V.C.I.]**. All use of **physical** force will consist of reasonable force or that force necessary to protect themselves~~,~~ and others from harm while accomplishing a lawful purpose **and within the parameters of Non-Violent Crisis Intervention training**~~.~~

C. **PROCEDURE:**
1. While the following guidelines generally apply, a Security Officer may use only ~~that~~ **physical** force which is reasonable and necessary **as well as physical force which would temporarily neutralize an imminent physical threat in order** to protect themselves, staff, visitors, and patients from harm while accompanying a lawful purpose~~.~~
2. Use of force shall be used at the ~~Shift Lead O~~officer's discretion.
   a. To defend him/herself or others
   b. To effect an arrest for a violation of a serious felony/crime.
   ~~b.~~**c. To assist in the patient's care plan as per the specific instruction provided by authorized medical staff members**

3. The use of physical force shall be restricted.
   a. To circumstances authorized by law.
   b. To the level necessary to accomplish a lawful security task.
   ~~b.~~**c. To the training of N.V.C.I. practices**
4. Examples of force options consist of the following **but are not limited to**~~.~~
   a. Verbal contact and intervention **[first], situational proximity i.e. standing in the way / using your body as a deterrent [second], and then** ~~P~~physical ~~S~~strength **/ N.V.C.I. application techniques [last].** ~~and use of Special Equipment, Chemical Agent.~~
5. The Security Officer shall only choose the available force option that is reasonable and necessary to effectively control the situation.
6. Improper use of force **includes but is not limited to bodily-slams, limb manipulation or pressure-point applications, restriction of airway / asphyxiation, and the choke-hold maneuver**.
   a. The use of improper force occurs when the type or degree of force employed was excessive, unnecessary, or unreasonable **regardless of a sustained or reported injury.**~~.~~
   b. The use of improper force by any member of the Security Department will not be tolerated and will be subject to disciplinary action **up to termination**.
7. The reporting procedure for Use of Force will be as follows and shall be properly followed.
   a. When a Security Officer has utilized any force option(s), all Officers present shall report such use in ~~an incident~~ **their daily security** report.
   b. In an arrest situation, the arresting **Security** Officer shall~~,~~ within the crime report articulate those facts~~,~~ which let him/her to believe that a particular force option was reasonable and necessary.
   c. In all other situations when a particular level of force has been utilized against an individual, the involved **Security** Officer(s) shall report it on the approved report detailing the specific circumstances of the incident **[i.e. why physical force was used, what specific physical force technique was used, who provided an instructional order for the patient's care plan, physical description of the individual force was used against, and any reported injury or discrepancy with the use of force by a security officer]**.
   d. All **Security** Officer(s) witnessing the ~~U~~use of ~~F~~force by anyone on the Tri-City Medical Center campus shall document the ~~U~~use of ~~F~~force ~~o~~in a **their** ~~Security Department~~ **daily security** report.
8. For reporting purposes, the following are considered ~~U~~sse of ~~F~~force.
   a. Any ~~physical~~ force **where physical contact is made with another person and / or physical force** resulting in injury to the **security** ~~O~~officer or ~~S~~subject.
   ~~Use of a baton or other impact weapon where the subject has been struck.~~
   ~~Use of O.C. chemical agent.~~
   ~~Use of any pain compliance technique(s).~~
9. **While physical force is approved for security officers, physically assisting with a patient needs an instructional order asked by the security officer and directly provided from the authorized medical staff member involved with the patient's care plan [e.g. Doctor, Nurse, Psychiatric Liaison, or Administrator].**
   a. An instructional order is asked for when a security officer identifies a safety risk [i.e. patient elopement attempt, combative / violent behavior, self-harm, or a reasonable assumption that harm might occur when high-risk behavior is observed].
   b. An instructional order is provided by the appropriate medical staff member; the order / directions are for the patient's care plan. Security officers are not medical trained or certified and cannot make patient care plan decisions.
   c. Once the safety issue is determined or presumed, the security officer will intervene and act on the medical staff's behalf for safety reasons but will act within the parameters of this use of force policy as well as N.V.C.I. techniques.

The security officer's actions are their own, and liability is still theirs even with an instructional order.

~~a.~~**d. Examples of instructional orders are but not limited to: seeking authorization to physical intervene / stop the patient or stand in their way if a patient attempts to elope whether on a psychiatric or medical hold or if a patient attempts harm to self or others.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

ISSUE DATE: 11/10

SUBJECT: Use of Recording Device

REVIEWED DATE(S): ~~07/15~~
REVISION DATE(S): 09/15

POLICY NUMBER: 408

Department Approval:	~~07/15~~05/20
Environmental Health and Safety Committee Approval:	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval:	~~09/15~~ n/a
Board of Directors Approval:	09/15

A. **PURPOSE:**

1. To establish guidelines for the use of a Recording Device by a Security Officer.

B. **POLICY:**

1. The use of a Recording Device defined as any device designed to or has the capabilities to capture sound, for example but not limited to audio recorder, cell phone, video recorder, or hand-held computer, by a Tri-City Medical Center Security Officer will only be utilized after it has been approved through the Director of Safety/EOC, Director of Risk Management, Legal or Chief Compliance Officer and only if all parties in the area defined as a 30 foot radius from the device or anyone who may not be physically present but would be heard by the Recording Device would have given expressed written consent approving their voice to be recorded by the Security Officer prior to recording.

C. **PROCEDURE:**

1. Only Security Department personnel, who have received the appropriate approval through the Safety Officer, and by Tri-City Healthcare District Compliance Officer, with instruction in the laws and use of a Recording Device will be authorized to utilize a Recording Device during the course of their assigned duties.
2. In the event that it is determined that the use of a Recording Device is necessary and approved, the Officer will obtain a written consent from the parties within the defined 30 foot radius or anyone who may not be physically present but would be heard by the Recording Device before the recording can begin. This consent will acknowledge that the parties understand their voice will be recorded for a single session only.
3. If it is determined that the use of a Recording Device is necessary after the initial recording session, the Officer using the Recording Device will obtain a new consent form, even if the parties involved approved a prior session to be recorded and signed a consent form.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: April 2, 1991~~ ~~Reviewed: 5/94, 12/96, 3/02, 5/03, 11/06, 3/09, 5/11, 03/12, 5/13~~ ~~Revision: 3/02, 7/03, 5/11~~ ~~Approvals: Director of Security~~	~~Subject: Work Overtime~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM - # 106~~

ISSUE DATE: 04/91~~April 2, 1991~~ **SUBJECT:** **Work Schedule and Mandatory Overtime**

REVIEW DATE: 05/94, 12/96, 03/02, 05/03, 11/06, 03/09, 05/11, 03/12, 05/13 **POLICY NUMBER: 106**

REVISION DATE: 3/02, 07/03, 05/11

Department Approval:	**05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administration Approval:	**10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish a standard departmental procedure for the **department's schedule and mandatory overtime**~~documentation of worked overtime~~.

B. **POLICY:**

1. All Security Department Personnel shall follow the below listed procedure to insure that **safe staffing levels are maintained**~~they are given credit for any worked overtime~~. ~~Reference Administrative Policy #412 Work Schedule and Overtime Compensation.~~

C. **PROCEDURE:**

1. ~~Mandatory Medical Center / Security Department in-service training sessions~~**Schedule**.
   - ~~a. It will be the responsibility of each Security Officer to schedule during a worked shift any mandatory Medical Center in-service training session.~~
   - ~~b. Each Security Officer will be responsible to sign in on a department training sheet, listing the date and time attended.~~
   - ~~c. The Security Supervisor will be given in writing notification of any scheduling conflicts for any session. Appropriate notification will be maintained at all times, so that alternative options can be developed.~~
   - ~~d. A detailed written report, outlining all pertinent facts, will be immediately supplied to the Security Supervisor by an employee for nonattendance of a mandatory meeting or session.~~

a. **It will be the responsibility of each officer to check the provided department schedule on a routine basis because of its changes due to safe staffing requirements.**

b. **The schedule is projected one month in advance and is established so as to provide the optimal amount of officers on property for safe-staffing levels. There will be no accommodations made for any one-single security officer.**

c. **The Security Department's Leadership [Manager or Supervisor] has the authority to update or change the schedule on a safe-staffing level needed basis.**

2. ~~Routine Shift~~**Mandatory** Overtime **Rotation**

~~a. Prior to working any shift overtime the Security Officer will notify the Shift Charge/Lead Officer followed by the Security Supervisor and advise of the need for the overtime.~~

a. ~~It will be the responsibility of the Officer to supply to the Security Supervisor a written memo on the Officer's Kronos timesheet printout outlining the date, time, and reason for any approved overtime.~~

b. **In order to minimize health and safety risk to all staff, patients and visitors to the facility, a mandatory four hours overtime from the proceeding shift will be enacted when staffing falls below the minimum number needed to safely man fixed mandated posts as required and the capability to respond to emergency calls of service throughout the facility or parking areas.**

c. **A staff list will be created determining which staff member will be next to work the mandated overtime when necessary, but volunteers will be accepted first.**

d. **If / when the designated staff has worked their mandated overtime , their name will automatically be placed on the bottom of the list, and the second officer on the list will be moved to the top position to work the overtime on a rotating basis.**

e. **The security officers are responsible for knowing who is scheduled for the mandatory overtime and are encouraged to review the schedule daily.**

f. **A security officer may only work 12 hours total and no more.**

~~b.~~**g. Any non-adherence to this policy may lead to discipline up to termination.**

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 09/18

SUBJECT: Local Anesthesia In Operating Room

REVISION DATE(S): 09/18

Surgical Services Department Approval:	**~~01/18~~02/20**
Department of Anesthesiology Approval:	**~~03/18~~03/20**
Operating Room Committee Approval:	**~~07/18~~06/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/18~~09/20**
Administration Approval:	**~~09/18~~10/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **PURPOSE:**

1. To define the patient selection criteria and monitoring requirements for patients receiving local anesthesia without sedation in the Operating Room (OR).

~~1.~~**2. To provide guidance for patient assessment, patient monitoring, recognition and treatment of local anesthetic systemic toxicity (LAST), assessment for local anesthetic allergies, and documentation of patient care for patients receiving local anesthesia in the OR.**

B. **DEFINITIONS:**

1. Local anesthesia: the administration of a local anesthetic agent to one part of the body by ~~local~~**injection,** infiltration or topical application, usually administered by the surgeon.
2. ASA Physical Status Classification: American Society of Anesthesiologists Patient Physical Status Profile, classifying patients as:
   a. ASA I: Normal, healthy patient.
   b. ASA II: Patient with mild systemic disease.
   c. ASA III: Patient with severe systemic disease.
   d. ASA IV: Patient with a severe systemic disease that is a constant threat to life.
   e. ASA V: Moribund patient not expected to survive without the operation.
   f. ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes.
3. Local anesthetic systemic toxicity (LAST): An uncommon, potentially fatal, toxic reaction that occurs when the threshold blood levels of a local anesthetic are exceeded by an inadvertent, intravascular injection or slow systemic absorption of a large, extravascular volume of local anesthetic. Symptoms of toxicity include, but are not limited to:
   a. Metallic taste
   b. Numbness of the tongue and lips
   c. Auditory changes (e.g., tinnitus)
   d. Light-headedness
   e. Dysarthria (e.g., slurred speech)
   f. Shivering
   g. Tremors
   h. Confusion
   i. Agitation

j. **Syncope**
k. **Seizures**
l. **Coma**
m. **Tachycardia/hypertension (initially)**
n. **Bradycardia/hypotension (with increased toxicity)**
o. **Ventricular arrhythmias**
p. **Asystole**
q. **Respiratory arrest**

~~3.~~
~~a. Metallic taste~~
~~b. Tinnitus~~
~~c. Syncope~~
~~d. Visual disturbances~~
~~e. Numbness of tongue and lips~~
~~f. Confusion~~
~~g. Tremors~~
~~h. Shivering~~
~~i. Generalized seizures~~
~~j. Initial tachycardia/hypertension~~
~~k. Bradycardia/hypotension with increased toxicity~~
~~l. Respiratory arrest~~
~~m. Ventricular arrhythmias/cardiac arrest~~

C. **POLICY:**

1. **A preoperative nursing assessment shall be performed for the patient who will receive local anesthesia, including review of patient's:**
   a. **Allergies and sensitivities**
   b. **Age**
   c. **Height, weight, and body mass index**
   d. **Current medications and use of alternative/complementary therapies**
   e. **NPO status**
   f. **Medical history (i.e., history and physical, progress notes)**
   g. **Laboratory test results**
   h. **Diagnostic test results**
   i. **Baseline cardiac status (e.g., heart rate, blood pressure)**
   j. **Baseline respiratory status (e.g., respiratory rate, rhythm, SpO_2)**
   k. **Baseline skin condition for integrity (e.g., rash, breaks, ecchymosis)**
   l. **Baseline neurological status**
   m. **Sensory impairments (e.g., visual, auditory)**
   n. **Ability to tolerate required operative position with draping for the duration of the procedure**
   o. **Level of anxiety**
   p. **Level of pain**
   q. **Perceptions of surgery**
   r. **Need for intravenous access**
2. **The surgeon shall determine patient acuity preoperatively using ASA Physical Status Classification.**

~~1.~~**3.** Patients receiving local anesthesia in the OR are monitored by the Perioperative Registered Nurse (RN).
   ~~a. Patients requiring sedation in addition to local anesthesia are not eligible for nurse monitored care.~~

~~2.~~**4.** Patient selection criteria for local anesthesia:
   a. ASA I or II.
   b. Patient must be NPO prior to procedure time for:

i. Two (2) hours after clear liquids
ii. Eight (8) hours after solids

c. Patients must have a functioning IV.

~~3.~~**5.** Case selection for local anesthesia:
a. Minor procedures less than 60 minutes in duration.
b. The patient's cooperation is necessary for the procedure.

~~4.~~**6.** Cases performed under local anesthesia with nurse monitored care shall have "under local anesthesia" included on the **procedural** consent form.

~~5.~~**7.** Staffing requirements:
a. The RN monitoring the patient receiving local anesthesia shall have no other duties or responsibilities during the case.
b. RN's shall have documented competency on monitoring patients receiving local anesthesia and signs and symptoms of local anesthetic systemic toxicity.

~~6.~~**8.** The RN shall monitor/assess the patient continuously during the procedure and document every five (5) minutes or more often if significant changes in the patient's condition occurs during the procedure:
a. Blood Pressure
b. Heart Rate
c. Respiratory Rate
d. O_2 saturation
e. Level of sedation for adults using the RASS Scale:

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non-purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and Calm	
-1	Drowsy	Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice
-2	Light Sedation	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

f. Pain level

~~7.~~**9.** Document on the Sedation Flow Sheet.

~~8.~~**10.** Supplemental oxygen, suction apparatus, and emergency crash cart shall be readily available for use.

11. Medications shall be dispensed under the physician's order.

12. **The RN circulator shall document the local anesthetic administered, including the:**
a. Medication name
b. Strength
c. Total amount administered
d. Route
e. Time
f. Expiration date
g. Lot number
h. Response
i. Adverse reactions (if applicable)

13. **Monitor patient for signs and symptoms of an allergic reaction to a local anesthetic, including:**
    a. **Anxiety**
    b. **Bronchospasm**
    c. **Dizziness**
    d. **Dyspnea**
    e. **Erythema**
    f. **Edema**
    g. **Cardiac arrhythmias (i.e., tachycardia, bradycardia)**
    h. **Hypotension**
    i. **Nausea**
    j. **Pallor**
    k. **Palpitations**
    l. **Pruritus**
    m. **Rash**
    n. **Syncope**
    o. **Urticaria**
14. **The Surgery RN shall monitor the patient for signs and symptoms of LAST. If LAST occurs:**
    a. **Call for help (i.e., Page "Any Available Anesthesiologist STAT" to the OR and notify the OR Supervisor/designee to recruit available help [e.g., Anesthesia Tech, additional RN's])**
    b. **Maintain patient's airway**
    c. **Ventilate with 100% oxygen**
    d. **Call for the crash cart and 20% lipid emulsion bag (from Surgery Pyxis Medstation)**
    e. **Assist with basic or advanced cardiac life support**
    f. **Be prepared to establish or assist with IV access**
    g. **Be prepared to assist with the administration of 20% lipid emulsion therapy**

~~9.~~**15.** Monitor the patient for the desired response ~~and adverse reactions~~ to local anesthetic medications. ~~Toxicity may occur if large amounts of anesthetics are absorbed rapidly.~~

~~10.~~**1.** Medications shall be dispensed under the physician's order.

~~11.~~**16.** Post-procedure:
    a. Inpatients receiving local only anesthesia for surgery will be returned to their room upon completion of their procedure, unless there is a physician order for PACU recovery/observation.
    b. Same Day Surgery (outpatients) will be transferred to PACU post-procedure for discharge.

17. The circulating RN shall provide hand-off report to the post-procedure RN, including procedure performed, medications administered, IV's in place, and how the patient tolerated the procedure.

D. **REFERENCES:**

1. **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**
~~12.~~

AUDIT COMPLIANCE AND ETHICS COMMITTEE CONSENT AGENDA
ADMINISTRATION CONSENT AGENDA
October 15th, 2020

CONTACT: Roger Cortez, CCO/CPO

Policies and Procedures		Reason	Recommendations
Privacy Designated Record	514	DELETE	Forward to the Board for approval
Use and Disclosure of PHI:Records	515	DELETE	Forward to the Board for approval
Patient Access to Protected Health Information in the Designated Record Set	516	3 year review, practice changes	Forward to the Board for approval
Amendment of Protected Health Information	520	3 year review, practice changes	Forward to the Board for approval
Use and Disclosure of Information Regarding Media	523	3 year review, practice changes	Forward to the Board for approval
Facility Directory and Visiting Guidelines for Clergy	527	3 year review, practice changes	Forward to the Board for approval
Accounting of Disclosures of Protected Health Information (PHI)	528	3 year review, practice changes	Forward to the Board for approval
Notification to Pre-Hospital Personnel; Exposure to Infectious Disease	530	3 year review	Forward to the Board for approval
Sanctions for Non-Compliance with Privacy and Security Policies & Procedures	531	3 year review, practice changes	Forward to the Board for approval
Education & Training - Introduction & General Polices	545	3 year review, practice changes	Forward to the Board for approval
Education and Training; Distribution Certification of Code of Conduct and Policies	546	3 year review, practice changes	Forward to the Board for approval
Education and Training; General Annual Compliance Training Program	547	3 year review, practice changes	Forward to the Board for approval
Education and Training; Specific Training Programs	548	3 year review, practice changes	Forward to the Board for approval
Education & Training - Compliance Notices – Updates	550	DELETE	Forward to the Board for approval
Monitoring Compliance Auditing and Reporting - Exit Interviews	554	3 year review, practice changes	Forward to the Board for approval
Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities	556	3 Year Review, Practice Change	Forward to the Board for approval
Communicating and Reporting Compliance Concerns (Valuesline)	557	DELETE	Forward to the Board for approval
Responding to Compliance Issues - Introduction; Reports of Suspected Misconduct; Confidentiality	559	DELETE	Forward to the Board for approval
Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct	560	3 year review, practice changes	Forward to the Board for approval
Responding to Compliance Issues - Reports of Suspected Misconduct Investigation	561	3 year review, practice changes	Forward to the Board for approval
Responding to Compliance Issues; Remedial Action	562	3 year review, practice changes	Forward to the Board for approval
Development and Revision of Code of Conduct and Policies	564	3 year review, practice changes	Forward to the Board for approval
Development and Revision of Code of Conduct and Policies - Retiring Code of Conduct and/or Policies	567	DELETE	Forward to the Board for approval

AUDIT COMPLIANCE AND ETHICS COMMITTEE CONSENT AGENDA
ADMINISTRATION CONSENT AGENDA
October 15th, 2020

CONTACT: Roger Cortez, CCO/CPO

Referral Source Policies ; Contractual Arrangement with Physicians and Other Referral Sources	569	3 year review, practice changes	Forward to the Board for approval
Loans and Guarantees to Physicians_	571	3 year review, practice changes	Forward to the Board for approval
Business Courtesies to Physicians and Immediate Family Members	573	3 year review, practice changes	Forward to the Board for approval
Tracking Physician Remuneration and Non-Monetary Compensation	574	DELETE	Forward to the Board for approval
HIPAA Administrative Requirements	585	3 year review, practice changes	Forward to the Board for approval
Protected Health Information (PHI) Breach Response	586	3 year review, practice changes	Forward to the Board for approval
Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO)	592	3 year review, practice changes	Forward to the Board for approval
Minimum Necessary Requirements for Use and Disclosure of PHI	594	3 year review, practice changes	Forward to the Board for approval

Tri-City Health Care D
Oceanside, Californ

ADMINISTRATIVE POLICY
COMPLIANCE

DELETE – combined with Administrative Policy Compliance: Patient Access to Protected Health Information in the Designated Record Set

ISSUE DATE: 3/03

SUBJECT: Privacy: Designated Record Set

REVISION DATE: 9/05; 01/09

POLICY NUMBER: 8610-514

Administrative Content Expert Approval:	07/20
Administrative Policies & Procedures Committee Approval:	~~05/15~~07/20
Organizational Compliance Committee Approval:	09/20
Administration Approval:	10/20
Audit and Compliance Committee Approval:	~~06/15~~ n/a
Board of Directors Approval:	06/15

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

~~1. To define Tri-City Healthcare District **(TCHD)**'s Designated Records Set.~~

~~2. To identify the HIPAA Privacy regulations and TCHD policies that addresses the Designated Record **S**set.~~

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

~~1. The Tri-City Healthcare District (TCHD) Designated Record Set is defined as those documents, whether maintained in paper, film or electronic formats, that **(1)** comprise the individual patient's medical record as approved by the Medical Record Committee**TCHD**, that **(2)** comprise the individual patient's billing records, and **(3)** any documents used in whole or in part by Tri-City Healthcare District**TCHD** to make decisions about individuals, including copies from another health care provider's designated record set.~~

~~2. HIPAA refers to the Designated Record Set in addressing **addresses** patient rights. Patients have a right to inspect and copy the Designated Record Set as set forth in **(Administrative** Policy 8610-516). Patients have a right to request an amendment of **protected health information (PHI)** in the Designated Record Set as set forth in **(Administrative** Policy No. 8610-520).~~

~~3. All information in the Designated Record Set is protected health information (PHI), and is subject to TCHD's Privacy – Use and Disclosure Policy **(Administrative Policy No. 8610-515)**.~~

~~C. **PROCESS:**~~

~~1. Medical Record: **A**all TCHD Medical Record content must be approved by the Physician IT Council and Medical Executive Committee, and includes**, but is not limited to,** the following types of documents:~~

~~a. Demographic and payor documents.~~
~~b. Administrative documents.~~
~~c. Patient consent and authorization forms.~~
~~d. Clinical information from Licensed Independent Practitioners including Discharge Summaries, History and Physical Reports, Consultations, and miscellaneous procedure reports.~~
~~e. Physician Orders.~~
~~f. Progress Notes.~~
~~g. Laboratory and Medical Imaging reports.~~
~~h. Operative and Pathology Reports.~~
~~i. Reports from ancillary services.~~
~~j. Nursing care documentation.~~

~~2. Billing Records: All billing record forms must be approved by the Chief Financial Officer or designees. The content of the TCHD individual billing records include:~~

~~a. Universal Billing Form.~~

b. Itemized Statement.
c. Collections correspondence.

3. Other Information Sources to be included in **the** Designated Record Set. For the most part, this documentation will be maintained by the originating department or the Medical Records/Health Information Department.
a. X-ray films and electronic medical images.
b. Photographs and videos used for the delivery or monitoring of care and treatment. (Intra-procedure photos or videos, wound photos, etc.)
c. Copies of records from other providers.
d. Monitor strips and recordings (e.g. ECG, Fetal Monitor strips).

REFERENCES:

Administrative Policy 8610-515: Use and Disclosure of Protected Health Information; Records
Administrative Policy 8610-516: Patient Access to PHI; Patient Record
Administrative Policy 8610-520: Amendment to Protected Health Information

D. **REFERENCES:**

1. 45 Code of Federal Regulations (CFR) Section 164.501
2. 45 CFR Section 164.524
3. 45 CFR Section 164.526
Amendment to Protected Health Information 8610-520.

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – incorporated into Administrative Policy: Disclosure of Protected Health Information 513

ISSUE DATE: 12/02

SUBJECT: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: RECORDS

REVISION DATE: 9/05; 11/08

POLICY NUMBER: 8610-515

Administrative Content Expert Approval:	09/19
Administrative Policies & Procedures Committee Approval:	~~11/08~~10/19
~~Operations Team Committee Approval:~~	~~12/08~~
Organizational Compliance Committee Approval:	09/20
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval:	n/a
~~Professional Affairs Committee Approval:~~	~~01/09~~
Board of Directors Approval:	01/09

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

~~1. Establish policy and procedure for the release of information from the health record as a means to ensure the protection and privacy of patient health information in compliance with state and federal regulations. This policy addresses the following categories of circumstances for the release of protected health information:~~

~~2. Use and Disclosure of Health Information:~~

~~a. In order to carry out treatment, payment, and healthcare operations.~~

~~b. For which consent or authorization or opportunity to agree or object is not required.~~

~~c. For which Patient/Legal Representative authorization is required.~~

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

~~1. The protection of health information and appropriate release of information is a shared responsibility of all personnel to safeguard the information against loss, tampering, or access use by unauthorized persons. Guidance and complete information beyond the scope of this policy for release of information will be obtained from the California Health Care Association Consent Manual and Federal Register.~~

~~2. Disclosures of health information should be limited to the amount reasonably necessary as indicated by the individual authorizing release to achieve the purpose of the disclosure. TCMC personnel may exercise professional judgment in determining minimum necessary to achieve purpose of disclosure in a good faith belief that making a disclosure may avert a serious threat to health or safety.~~

~~3. Categories for the release of health information are as follows:~~

~~a. Use and disclosure of Health Information in order to carry out treatment, payment, and health care operations.~~

~~i. The Patient acknowledges receipt of the Tri-City Medical Center Notice of Privacy Practices on admission. Examples of this type of information include but are not limited to:~~

~~ii. Transfer and communication of pertinent health information for continuing care to another care provider by staff caring for the patient.~~

~~iii. Health care providers, when necessary for the care of the patient or assistance in obtaining payment for health care.~~

~~iv. Third parties who are directly connected with payment~~

~~v. Students seeking information from the records of a discharged patient to whom the student provided direct patient care must present a written notice from their~~

respective instructor, stating the patient's name, and must present valid student identification.

vi. Information on the facility directory.

b. Disclosure for which consent or authorization or opportunity to agree or object is not required.

i. Information may be released to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

ii. This situations include but are not limited to:

1) Health care oversight, public health activities and authorities
2) Reasonably believe the patient may be a victim of abuse, neglect or domestic violence
3) Internal and external audits, civil, administrative, or criminal investigations
4) Judicial and administrative proceedings, court orders, subpoenas
5) Law enforcement officials, when statutory reporting is required.
6) Decedent information, to medical examiner, funeral directors
7) Research purposes
8) Tissue donation or transplant, organ procurement
9) Specialized government functions, i.e. military, veterans
10) To avert a serious threat to health or safety
11) Workers compensation or similar programs established by laws that provide benefits for work related injury or illness.

iii. Verify the identity of persons and his/her legal authority to make the request for protected health information. (Examples include asking to see a badge or other proof of identity of government officials.) May rely on the statements of governmental officials and others regarding legal authority.

iv. Obtain appropriate documentation, statements or representations whether written or oral from the person requesting the protected health information when such documentation is a condition of the disclosure (i.e. administrative subpoena).

v. Requests for release of information in this category may be referred to a supervisor for review. The California Healthcare Association Consent Manual should be referenced for guidance and release criteria. If necessary, the Privacy Officer may be contacted for consultation and additional guidance.

vi. Documentation of compliance with these requests will be included in the Accounting of Disclosures available to the patient.

c. Disclosure for which Patient/Legal Representation authorization is required.

i. Authorization must be obtained for the release of "Individually Identifiable Medical Information." Defined as, medical information that includes or contains any element of personal identifying information sufficient to allow identification of the individual. This includes information that alone or in combination with other publicly available information reveals the individual's identity.

ii. Health information containing "sensitive information" as defined below is subject to additional release requirements:

1) Behavioral Health or Psychiatric Diagnoses
2) HIV/AIDS
3) Communicable Disease
4) Drug and alcohol

iii. Information received from another source will be considered a part of the patient's medical record and thus will be "re-disclosed" in compliance with the minimum necessary requirements. Examples are as follows:

1) Admitting orders from a staff physician's office
2) Pre-op consents completed in a physician's office
3) Pre-op laboratory/imaging/cardiology work-up
4) History and Physical report from the staff physician's office
5) Pre-natal records

iv. Authorization must include:

1) Description of the information to be used or disclosed with sufficient specificity to allow our organization to know to which information the authorization refers.
2) Identifies sufficiently the covered entity or entities that would be authorized to use or disclose the protected health information by the authorization.
3) Identifies the person or persons that would be allowed to use or receive the protected health information with sufficient specificity to reasonably permit a covered entity responding to the authorization to identify the use or receipt.
4) Specify an expiration date
5) Include signature or other authentication and date of signature
6) Statement that the individual understands they can revoke an authorization except to the extent that action has been taken in reliance on the authorization.

v. Authorization for Use or Disclosure Form must be completed and delivered to the Medical Records/Health Information department for processing and inclusion in the information release accounting of disclosures process.

C. **RESPONSIBILITIES:**

1. All personnel providing services within Tri-City Medical Center to include but not limited to, employees, volunteers, physicians, Allied Health Professionals, students and affiliated business associates are responsible for awareness of policy and for protecting patient health information from unauthorized release.
2. Medical Records/Health Information personnel and in their absence, Administrative Coordinator, charge nurse or designee may respond to requests for health information during a patient's hospitalization. Requests for information in closed medical records will be processed through the Medical Records/Health Information Department.
3. Medical Records/Health Information Department personnel are responsible for maintaining an accounting of all release of information whether patient authorization has or has not been obtained.

D. **PROCESS:**

1. Release only information to fulfill the purpose stated on the request to an authorized individual/agency. "Authorized individual" is defined as:
   a. Adult (18 years or older) who is currently or was formerly in receipt of health care services at the facility.
   b. Minor, under 18 years of age must have permission of the parent or guardian to access their records except in the following circumstances:
      i. Emancipated minors (in addition to other specified categories of minors), as specified by law, may inspect or request copies of part or all of their health record.
      ii. Pregnancy
      iii. Drug abuse
      iv. Mental health
      v. Reportable disease
      vi. Rape
      vii. Sexual assault
   c. Parent or Legal Guardian
   d. Conservator
   e. Power of Attorney for Health Care
   f. Physician on staff
2. Release of "Sensitive Information":
   a. Patient health information content is screened for "Sensitive Information" prior to release.
   b. Records containing such information are subject to additional requirements for release as follows:
      i. Fax or electronic communications is limited to emergency situations only.
      ii. Patient or authorized individual must specifically check on the consent/authorization form that the Medical Center has their permission to release

the specific category of information (i.e. HIV test results, behavioral health information)

iii. Stamp documents with the following information:

1) "This information has been disclosed to you from records whose confidentiality is protected by federal law, federal regulation 42 CFR, Part 2 which prohibits you from any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization from the release of medical or other information is not sufficient for this purpose."

iv. Behavioral Health information must be reviewed by the attending physician, Behavioral Health Unit Director, or Chief of Staff and approved for release if the patient is asking for copies for their personal use. If approval for release is not obtained, the physician denying the release will provide a statement for inclusion in the medical record. The requesting individual will be directed to the reviewing physician for further explanation or inquiry.

c. Complete the following data for the release of information utilizing "Authorization for:

i. Use or Disclosure of Health Information."

ii. Patient's Name and Date of Birth.

iii. Name and Address of individual requesting information.

iv. Extent or nature of information to be released with inclusive dates of treatment. An authorization specifying "any and all information" shall not be honored. (Description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion.)

v. Information (copies of), produced at another facility should not be released unless specifically authorized by the patient on the release of information request.

vi. Date upon which the release will expire. (not to include future visits)

vii. Statement of the individuals right to revoke the authorization in writing and the exceptions to the right to revoke, together with a description of how the individual may revoke the authorization.

viii. Proposed use of released information.

ix. Signature of the patient or legal representative to include their authority or guardian authorizing release.

x. Date and time authorization is signed.

d. Identify individual requesting information:

i. Photo identification.

ii. Telephone direct callback to requesting individual. (i.e. MD offices, mortuary)

e. Phone, fax and electronic transmission of health information:

i. Limited to urgent situations

ii. Third party payer with whom TCMC has a business agreement for certification of payment.

iii. Information necessary to obtain aftercare placement.

iv. Health data reporting. (i.e. CDC)

v. Phone/Fax emergency situations only, complete Authorization for Use and Disclosure form reflecting that the patient is unable to sign and Durable Power of Attorney for Healthcare agent is not available.

f. Release health information in copy form only. Original health records can be removed from the Medical Center only by court order, statute, or subpoena. An exception may be made for off-site storage or for authorized use by the Medical Center in litigation.

g. Accounting of disclosures will be maintained by Medical Records/Health Information to include:

i. "Authorizations for Release of Information" filed with the health record, but not incorporated as part of the health record. Documentation of information should not be disclosed when the patient's health record is subsequently requested unless such documentation is specifically sought.

ii. Log of all requests for release of health information.

iii. Patients may request an accounting of disclosures made by the Medical Center for

~~a period of 6 years from the 1st request, effective April 14, 2003. Written accounting of disclosures will be processed within 60 days and include:~~

~~1) Date of disclosure.~~
~~2) Person to whom information was disclosed.~~
~~3) Brief description of information disclosed.~~
~~4) No charge assessed for one accounting per year.~~

~~E. **ADJUNCT POLICIES:**~~

~~1. AP # 516, Patient Access to Protected Health Information – Patient Record~~

~~F. **REFERENCES:**~~

~~1. Authorization for Use or Disclosure form~~
~~2.~~1. ~~California Healthcare Association Consent Manual – 2005, Federal Law 42 CFR, Part 2~~

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 12/02

SUBJECT: Patient Access to Protected Health Information in the Designated Record Set

REVISION DATE: 4/03; 9/05; 11/08

POLICY NUMBER: 8610-516

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~11/15~~07/20
Administrative Policies & Procedures Committee Approval:	~~11/15~~07/20
Organization Compliance Committee Approval:	09/20
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval	~~01/16~~ n/a
Board of Directors Approval:	01/16

A. **PURPOSE:**

1. To establish policies and procedures for providing a Patient or his or her Personal Representative with access to, and copies of, the Patient's Protected Health Information (PHI) in a Designated Record Set.

B. **DEFINITIONS:**

1. Alcohol and Drug Abuse Records: ~~patient~~ **Patient** records, or discrete portions thereof, specifically relating to evaluation and treatment of alcoholism or drug abuse.
2. Adult: ~~person~~ **PersonIndividual** who has reached the age of 18, or a minor who has entered into a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the USA, or who has been declared emancipated.
3. Authorization: ~~the~~ **The** written form that complies with HIPAA and state law that is obtained from the ~~Individual~~ **Patient** or his or her Personal Representative in order for Tri-City Healthcare District (TCHD) to **u~~U~~se** and **d~~D~~isclose** PHI.
4. **Billing Records: The content of the TCHD individual billing records include:**
   - **a. Universal Billing Form~~.~~**
   - **b. Itemized Statement~~.~~**
   - **c. Collections correspondence~~.~~**

~~4.~~**5.** Designated Record Set: ~~those~~ **Those** documents, whether maintained in paper, film or electronic formats, that comprise the ~~Individual's~~ **Patient's Health**~~medical~~ **R~~r~~ecord** as approved by the Medical Executive Committee, that comprise the ~~Individual's~~ **Patient's B~~b~~illing R~~r~~ecords**, and any **and all other** documents used in whole or in part by TCHD to make decisions about ~~individuals~~ **Patients,** including copies from another **H~~h~~ealth C~~c~~are P~~p~~rovider's designated record set.

~~5.~~**6.** Health Care Provider: ~~any~~ **Any** of the following:

a. Licensed health facility;
b. Licensed health clinic;
c. Licensed home health agency;
d. Licensed physician and surgeon;
e. Licensed podiatrist;
f. Licensed dentist;
g. Licensed psychologist;
h. Licensed optometrist;
i. Licensed chiropractor;
j. Licensed marriage, family, and child counselor;
k. Licensed clinical social worker

7. **Health~~Medical~~ Record: Includes the following types of documents:**

a. **Demographic and payor documents.**
b. **Administrative documents.**
c. **Patient consent and authorization forms.**
d. **Clinical information from Allied Health Professional~~Licensed Independent Practitioners~~ including Discharge Summaries, History and Physical Reports, Consultations, and miscellaneous procedure reports.**
e. **Physician Orders.**
f. **Progress Notes.**
g. **Laboratory and Medical Imaging reports.**
h. **Operative and Pathology Reports.**
i. **Reports from ancillary services.**
j. **Nursing care documentation.**
k. **X-ray films and electronic medical images.**
l. **Photographs and videos used for the delivery or monitoring of care and treatment. (Intra-procedure photos or videos, wound photos, etc.)**
m. **Copies of records from other providers.**
n. **Monitor strips and recordings (e.g. ECG, Fetal Monitor strips).**

~~6.~~**8.** Mental Health Records: ~~patient~~ **Patient** records, or discrete portions thereof, specifically relating to evaluation or treatment of a patient's mental health condition or mental disorder. "Mental Health Records" include~~s~~, but is not limited to, all Alcohol and Drug Abuse Records. ~~"Mental Health Records" also includes, but is not limited to, all alcohol and drug abuse records.~~

~~7.~~**9.** Minor (**E**~~e~~mancipated): ~~patient~~ **Patient** 14 years of age or older who has petitioned the court for emancipation. Identification (ID) card stating the minor is emancipated is issued by the Department of Motor Vehicles (a copy of this ID card is to be placed in the **P**~~p~~atient's medical record).

~~8.~~**10.** Minor (**S**~~s~~elf-**S**~~s~~ufficient): ~~patient~~ **Patient** 15 years of age or older ~~is~~ living separate and apart from ~~his/her~~**their** parent or legal guardian~~,~~ and manages ~~his/her~~**their** own financial affairs regardless of source of income.

~~9.~~**11.** Patient: ~~a A person~~ **An individual** who is currently or was formerly a patient of ~~Tri-City Healthcare District~~**TCHD**.

~~10.~~**12.** Personal Representative: ~~the~~ **The** ~~person~~ **individual** who has the authority to act for the ~~Individual~~ **Patient** in making decisions related to health care under state law (except where an unemancipated **M**~~m~~inor has the authority to act as ~~an Individual~~**a Patient** for certain services or circumstances) or, with respect to deceased ~~persons~~**Patients**, the ~~person~~ **individual** who has the authority to act on behalf of the deceased ~~Individual~~ **Patient** or the ~~Individual's~~ **Patient's** estate as relevant to such personal representation.

~~11.~~**13.** Protected Health Information (PHI): ~~individually~~ **Individually** identifiable health information transmitted or maintained in electronic or paper form that is created or received by TCHD ~~AND~~**and**:

a. Relates to the past, present, or future physical or mental health or condition of a~~n individual~~ **Patient**; ~~OR~~**or**
b. Relates to the provision of health care to a~~n individual~~ **Patient**; ~~OR~~
c. Relates to the past, present, or future payment; ~~AND~~**and**
d. Identifies the ~~individual~~ **Patient** ~~OR~~ **or** with respect to which there is a reasonable basis to believe the information can be used to identify the ~~individual~~**Patient**.

C. **POLICY:**

1. It is the policy of TCHD to provide Patients or their Personal Representative ~~(to the extent relevant to the representation)~~ with access to inspect and/or obtain copies of ~~PHI in~~ the Designated Record Set within the time required by law.
2. TCHD may deny requests to access Mental Health, Alcohol and Drug Records, and other records in the ~~DRS~~ **Designated Record Set** as specified in this Policy but only if the requirements for denial set forth in this Policy and applicable law are met.

D. **PROCEDURES:**

1. Patient Access to Information in the Designated Record Set
   a. Right of Access to Information in the Designated Record Set
      i. Adult Patients and Personal Representatives shall be entitled to inspect records and to obtain copies of all or any portion of **P**~~p~~atient records upon presentation of a written Authorization.
   b. Responsibility for Processing Requests for Patient Access
      i. The ~~Medical Records/~~Health Information Management Department (~~"MRD/HIM Department"~~) shall be primarily responsible for processing requests for Patient access to records post-discharge.
      ii. ~~MRD/~~HIM ~~Department~~ staff shall not attempt to explain or interpret anything in records. If any assistance in understanding information contained within the **Designated R**~~r~~ecord **Set** is required, the Patient or Personal Representative~~-~~ shall be referred to the responsible Health Care Provider.
      iii. In situations in which the Patient ~~-~~is currently an inpatient or Home Care Patient, ~~the MRD/~~HIM ~~department~~ will work with the nursing **leadership**~~unit manager or case manager~~ to ensure **a** proper Authorization is obtained. ~~The procedures set forth in D.1.c through D.1.i shall be followed..~~
   c. Requirements for Requests for Patient Access to Records
      i. Requests for Patient access to Patient's ~~**medical**~~**Designated R**~~r~~ecord **Set**~~s~~ must be made in writing and **the Request to Amend P**~~p~~**rotected Health Information form completed. At a minimum, the following information must be provided.** ~~must provide the following information:~~
         1) Name of the Patient whose records are requested~~;~~
         2) Name and signature of the requester~~;~~
         3) A statement of the relationship to the Patient, if the requester is a Personal Representative~~;~~
         4) Identification of the portion of the record to be inspected or copied~~;~~ ~~and~~
         5) Date of the request~~;~~
         6) Length of time the request is valid~~;~~
         7) Date of birth of Patient~~;~~ **and**
         8) Reason for Disclosure~~.~~
   d. Procedure for Processing Requests for Patient Access.
      i. Records shall be reviewed by the ~~Medical Records/Health Information Department~~**IM** staff prior to permitting inspection, or providing copies to ensure:
         1) Integrity of the record~~;~~
         2) Completeness of the record~~;~~
         3) Appropriateness of requests of **M**~~m~~inor Patients~~;~~ and
         4) **Obtain**~~**ing**~~ **approval from the H**~~h~~**ealth C**~~c~~**are P**~~p~~**rovider to release records that pertain to** ~~Consideration of possible adverse determination on records of~~ Mental Health Records, including Alcohol and Drug Abuse Records.
   e. TCHD shall consult with **compliance and** ~~legal~~**general counsel** ~~denials~~**on denials** of access to records that make reference to other persons or where the request is made by a Personal Representative and a licensed provider has determined, in ~~his or her~~**their** professional judgement, that access is reasonably likely to cause substantial harm to the **P**~~p~~atient or another ~~person~~**individual**.
   f. If a record is incomplete, the requestor shall be given the option of waiting until the record is complete, or accessing the record prior to completion. When possible, completion of incomplete records shall be expedited.
   g. Access to records shall not be denied or delayed because the ~~Patient~~ **P**~~p~~**atient** is still undergoing care. Such a request may signal dissatisfaction with care, therefore, the Health Care Provider ~~-~~shall be notified and encouraged to participate in the review personally in order to clarify any questions. ~~The Medical Records/Health Information~~

~~Department~~**HIM** staff shall assist the nursing staff in the handling of the Patient- request form. **The P~~p~~atient shall also be directed to the patient portal.**

h. Documentation of Requests for Patient Access -to Patient Records.
   i. Release of any **P~~p~~**atient records shall be documented by the ~~Medical Records/Health Information~~ **HIM** ~~team~~**staff**, who shall record the following information:
      1) A copy of the written request~~;~~
      2) Date the request was received~~;~~
      3) Date and manner of compliance~~;~~ and
      4) Name of the person who released the information pursuant to the request.

i. Patient Inspection of Records
   i. TCHD maintains most records in the Designated Record Set in electronic form. If a patient or Personal Representative wants to personally inspect the Patient's records, TCHD is not required to provide the Patient or Personal Representative with access to its electronic system. Instead, TCHD will print copies of the electronic record for inspection, upon proper written request. Such records shall be made available for inspection by Patients or Personal Representatives within five (5) working days of the hospital's receipt of a written request.
   ii. Inspections may be carried out during business hours by appointment only. Inspections shall be carried out in the **HIM**~~Medical Records/Health Information Department~~, and shall be under the direct visual supervision of designated ~~MR/~~HIM ~~Department~~ staff.
   iii. Reasonable efforts to establish the identity of the Patient or the Personal Representative shall be made prior to the beginning of inspections. Pursuant to applicable law, efforts to establish the identity of the Patient or the Personal Representative shall not be used oppressively or discriminatorily to frustrate or delay Patients' and Personal Representatives' rights to access records.
   iv. One individual may accompany the Patient or Personal Representative during the inspection. If the Health Care Provider elects to participate in the inspection, the Patient or Personal Representative may choose one additional person to participate.

j. Provision of Copies of Records
   i. Patients and Personal Representatives shall have the right to receive copies of all or a portion of records in the Designated Record Set. TCHD **can** provide~~s~~ electronic medical records on CDs **if the Ppatient or ~~patient~~ Personal Rrepresentative requests such.** ~~.~~ **The** CDs shall be provided to Patients or Personal Representatives within fifteen (15) calendar days of TCHD's receipt of a valid written request.
   ii. Reasonable efforts to establish the identity of the p**P**atient **and** ~~of~~ the Personal Representative shall be made prior to the provision of copies in accordance with TCHD Administrative Policy No.8610-593. Pursuant to applicable law, efforts to establish the identity of the Patient or the Personal Representative shall not be used oppressively or discriminatorily to frustrate or delay Patients' rights to access records in the Designated Record Set.

k. Provision of Electronic **Access to** ~~copies of~~ **to** PHI
   i. If a Patient requests access to electronic PHI, TCHD must provide an electronic PHI. TCHD is not required to provide direct access to its computer systems. TCHD will provide a copy of electronic PHI on CD.

2. Access to Patient Records of Minors
   a. General Right of Access
      i. Emancipated **M~~m~~**inor Patients shall have access to their ~~health information~~**PHI** with provision of appropriate documentation as provided in TCHD Administrative Policy No. 8610-593.

ii. Minor Patients shall have the right to access their ~~patient~~ **Patient** records only when those records pertain to treatment to which the **M**~~m~~inor has the right to consent:
1) Pregnancy related conditions
2) Treatment for an ~~infections~~**infectious**, contagious, or communicable disease which must be reported to the local health officer
3) Treatment for a sexually transmitted disease
4) Treatment for rape
5) Outpatient mental health treatment
~~5)~~**6) Drug and Alcohol Abuse Treatment**

iii. When **M**~~m~~inor~~s'~~ **P**~~p~~atient**s'** records pertain to such treatments, parents or guardians shall not have the right to inspect or copy such records, unless the **M**~~m~~inor ~~Patient~~ **Ppatient provides a written Authorization,**~~consents.~~

iv. Parents or guardians of **M**~~m~~inor Patients shall have the general right, as Personal Representatives~~,~~ to inspect or copy **M**~~m~~inor~~s'~~ Patient**s'** records, except as noted above.

v. A parent or guardian's request to access a **M**~~m~~inor~~'s~~ Patient**'s** records shall be denied if the Health Care Provider determines that access to Patient records, including Mental Health Records, will have a detrimental effect on the **M**~~m~~inor's physical safety or psychological well-being, or on the Health Care Provider's professional relationship with the **M**~~m~~inor.

vi. Access to a **M**~~m~~inor Patient's ~~medical~~ **Designated R**~~r~~ecord **Set** and information to which the parent is otherwise entitled may not be denied to a parent solely because the parent is not the child's custodial parent.

b. Denial of Requests to Access Minor~~s'~~ Patient**s'** Records

i. When a parent or guardian's access to a **M**~~m~~inor~~'s~~ Patient**'s** record is denied, the Health Care Provider shall make a written record, to be included with the Patient record, noting the date of the request and explaining the Health Care Provider's reason for refusing to permit inspection or provide copies of the Patient's record, including a description of the detrimental effect that the **Health Care P**~~p~~rovider anticipates would occur if access were permitted.

c. Requests for Access to Minors' Alcohol and Drug Abuse Records

i. Requests by parents or guardians to review **M**~~m~~inor's Alcohol and Drug Abuse records **is prohibited under Federal law without the M**~~m~~**inor's written** ~~consent~~**Authorization. The** ~~physician~~**Health Care Provider may disclose to parents/**~~patient~~ **Personal R**~~r~~**epresentative under three conditions without the M**~~m~~**inor Patient's written consent:**~~.~~ **1) The M**~~m~~**inor poses a substantial threat to the life or physical well-being of the M**~~m~~**inor or another; (2) The threat may be reduced by communicating relevant facts to the M**~~m~~**inor's parents; or (3)** ~~That the~~**he M**~~m~~**inor lacks the capacity because of extreme youth or a mental or physical condition to make a rational decision on whether to disclose to parents.** ~~shall be referred to the Director or Operations Manager of Medical Records/Health Information.~~

3. Access to Suspected Child Abuse Records

a. Requests for release of suspected child abuse records to a Patient or Personal Representative should be referred to the Director ~~or Operations Manager~~ of Medical Records/Health Information who will coordinate review of the request with the Case Management/Social Services Manager.

4. Access to Records of Deceased Patients

a. A Patient's Personal Representative's request to access a deceased Patient's ~~-~~record shall include verification or the identity and authority of the Personal Representative in accordance with TCHD Administrative Policy No. 8610-593.

b. A Personal Representative whose identity is verified shall have the same right to ~~medical~~**the Designated Record Set** ~~inspect or copy records~~ as the Patient.

c. A request by a verified Personal Representative to access a deceased Patient's records shall be processed in the same manner as a Patient's request for access to **their** ~~his/her~~ own record.

d. An abstract of Minimum Necessary documents is provided free of charge for Personal Representatives requesting copies of the deceased Patient's record.

5. Access to Mental Health Records

a. Review of Requests to Access Mental Health Records.

i. The appropriate Health Care Provider shall be notified when a Patient requests access to ~~his/her~~**their** Mental Health Records. In those cases where it is difficult to determine if a record is a Mental Health Record, the request should be directed to the Director ~~or Operations Manager of the Medical Records/Health Information Management (MR/HIM) Department~~**of HIM**. Access to ~~such~~ Mental Health Records shall only be denied where the Health Care Provider determines that there is a substantial risk of significant adverse or detrimental consequences to the Patient in seeing or receiving a copy of the Mental Health Records.

ii. A request by a ~~patient~~ **Patient** to ~~inspect or~~ receive copies of Mental Health Records shall be honored if the ~~MR/~~HIM Department has not been advised by the Health Care Provider by the fifth (5th) business day after notification that denial is recommended. Every effort shall be made to reach the Health Care Provider for approval and steps taken will be documented. If the Health Care Provider cannot be reached, the request for access shall be referred to the Chair of ~~the Psychiatric Division or the Medical Director of the Behavioral Health Unit. If the Chair cannot contact the Health Care Provider, the Chair of the Psychiatric Division shall make the determination regarding release or denial of Mental Health records and the need for an alternate summary within 5 business days.~~**Staff**

iii. Actions taken will be documented with resolution within ~~5 business days for access and within~~ 14 days from receipt of request for copies.

6. Requests to Access Alcohol and Drug Abuse Records

a. Patient records specifically related to alcohol or drug abuse evaluation or treatments are considered Mental Health **R**~~r~~ecords under the **California** Health and Safety Code~~.~~[4] **and shall be treated in the same way as 5a above.**

~~a.~~**b.** ~~–~~Patient requests to ~~access adult Alcohol and Drug Abuse records shall be handled in the patient's requests to~~ release **A**~~a~~lcohol and **D**~~d~~rug **A**~~a~~buse **R**~~r~~ecords to the **P**~~p~~atient's attorney shall be treated, as a request for disclosure to a third party, and the appropriate procedure for such release shall be followed.

7. Denial of Requests to Access Mental Health Records.

a. When **P**~~p~~atient access to Mental Health **R**~~r~~ecords is denied, the Health Care Provider shall make a written record **of the denial and include it** ~~, to be included~~ with the Mental Health **R**~~r~~ecords. The written record shall note the date of the request and explain the Health Care Provider's reason for refusing to ~~permit inspection or~~ provide copies of the Mental Health ~~-R~~records, including a description of the specific adverse or detrimental consequences to the **P**~~p~~atient that the ~~provider~~ **Health Care Provider** anticipates would occur if inspection or copying were permitted.

b. **The** ~~MR/~~HIM Department ~~team~~ shall inform the **P**~~p~~atient of the Health Care Provider's refusal to permit inspection or copying of the records~~,~~ and shall inform the **P**~~p~~atient that ~~he or she has~~**they have** the right to permit inspection by or provide copies to the following licensed ~~professionals~~ **Health Care Providers** as designated by the **P**~~p~~atient:

1) A licensed physician and surgeon
2) A licensed psychologist
3) A licensed marriage and family therapist~~;~~
4) A licensed clinical social worker~~; or~~
5) A licensed professional clinical counselor~~.~~

c. **The** ~~MR/~~HIM Department ~~team~~ shall document in the **P**~~p~~atient record that the **P**~~p~~atient was informed of ~~his or her~~**their** right to designate a licensed physician, psychologist, or social worker to review the Mental Health Record- or obtain copies, and shall document whether the Patient chose to exercise this right.

d. If the **P**~~p~~atient chooses to designate a licensed physician, psychologist, social worker or clinical counselor to **obtain copies** ~~review~~ **of** the Mental Health Record ~~or obtain copies,~~ statutes governing access to non-patients shall apply, including the requirement of a valid written **A**~~a~~uthorization from the **P**~~p~~atient for such **D**~~d~~isclosure. A reasonable effort shall be made to verify that the ~~person~~ **individual** named to obtain copies is, in fact, a licensed professional.

8. Release of Patient Records to a Patient's Attorney

a. Right to Request Release of Patient Records to an Attorney

i. Prior to the filing of a claim or action, records shall be released to a Patient's attorney upon receipt of a proper written Authorization.

b. ~~A Process for Complying with~~ Requests for ~~Release~~ **release needs to be ~~filled out~~signed by the P~~p~~atient in order to release records to the P~~p~~atient's** ~~to an Attorney~~**attorney**

i. A written **A**~~a~~uthorization for release of records to an attorney shall contain the following items:

1) The name of the facility;
2) The name of the person or company to whom the information will be given;
3) The date of the Authorization; and
4) The signature of the Patient or the Personal Representative

ii. Pursuant to a proper written Authorization, records shall be released to a photocopier or agent whom the requesting attorney has employed to obtain or review the records.

iii. Presentation of the written **A**~~a~~uthorization by the professional copier or agent shall be sufficient proof that the person is authorized to access the ~~records~~**Designated Record Set**.

iv. When a requesting attorney has employed a professional photocopier or agent to access the **P**~~p~~atient ~~records~~**Designated Record Set**, neither ~~the hospital~~**TCHD** nor any Health Care Provider shall make copies of the record to comply with the request.

v. If the requesting attorney has not employed a professional photocopier or agent, records may be copied by ~~the hospital~~**TCHD** or a Health Care Provider, or be made available for inspection by the attorney or the attorney's agent.

c. Time for Providing Access to Patient's Attorneys

i. Records shall be made available to a Patient's attorney within five (5) business days after receipt of a proper written Authorization.

9. Summaries Provided in Lieu of Patient Access to Records

a. Process for Completing Summaries

i. A Health Care Provider may opt to provide a summary of the record as an alternative to providing access to or copies of the entire **P**~~p~~atient record but only if the Patient agrees in advance, to the summary and any related fees. The ~~patient~~ **Patient** or Personal Representative shall elect either to inspect or to receive a copy of such a summary.

ii. ~~MRD/~~HIM ~~staff~~ shall oversee Health Care Providers' preparation of summaries, and shall ensure that requests for Patients' records involving summaries are processed promptly in order to allow sufficient time for dictation and transcription of the summary.

iii. If the Health Care Provider provides a summary in lieu of access to the entire record, the Health Care Provider may confer with the Patient or Personal Representative in an attempt to clarify the purpose or goal in obtaining the Patient's records. If the Patient or Personal Representative requests information

only pertaining to certain injuries, illnesses, or episodes of care, the summary need only pertain to the specified injuries, illnesses or episodes of care.

iv. TCHD shall refer to the requirements under HIPAA and State law related to the time and manner of providing summaries and charges for summaries. ~~th~~
~~1) Progress of the treatment;~~
~~2)~~

10. Fees for Medical Record Requests
    a. Fees for Inspection or Copying by Patients/Personal Representatives
        i. TCHD does not charge for making electronic records available to Patients or Personal Representatives on CDs. If Patients or Personal Representatives ~~want~~ **request** a hard copy of the ~~full medical~~**Designated R**~~r~~ecord **Set**, copies are charged at the rate of $0.~~10~~ **25** per page. Copies reproduced from microfiche/microfilm are charged at the rate of $0.**5**~~2~~0 per page.
        ii. Patients and Personal Representatives shall not be charged for the processing of routine requests for inspection.
        iii. Patients and Personal Representatives shall not be charged for the provision of copies of **P**~~p~~atient records being forwarded to a ~~physician~~ **Health Care Provider** for continuing care.
        iv. Patients and Personal Representatives shall not be charged for provision of a continuing care abstract of information from the record. The abstract will include the following document types:
            1) All dictated reports (H&P, CON, OP, Discharge Summary)
            2) All Laboratory and Pathology reports (internal and external)
            3) Cardiology reports (ECGs, invasive and non-invasive procedures)
            4) Imaging reports (including interventional)
    b. Fees for Attorney Requests
        i. A fee not to exceed $15.00 shall be charged to a party requesting access to a Patient's records for inspection or copying by a professional photocopier or agent employed by an attorney.
        ii. When no professional photocopier or agent is employed by a Patient's attorney, TCHD may charge the reasonable cost of providing copies:
            1) Copying standard documents: $.~~10~~ **25** per page
            2) Copying microfilm/microfiche documents: $.~~20~~ **50** per page
            3) Actual postal costs for providing records
            4) Actual costs for retrieval of records held off-site.

E. ~~**DENIAL OF RIGHT TO ACCESS:**~~

~~1. Patients and Personal Representatives have a right to inspect and copy his or her records except for mental health records under specified circumstances and copies of x-rays or tracings in certain circumstances.~~

~~2. TCHD may deny a Patient's or Personal Representative's right to access the Patient's information in certain circumstances. TCHD must provide the Patient or Personal Representative, as applicable, with access to any other PHI requested after excluding the PHI for which TCHD a ground to deny access.~~

~~3. TCHD must give the Patient or Personal Representative written notice of the denial (whether in whole or in part) within five (5) working days. The notice must contain the following information:~~
~~a. An explanation of the basis for the denial;~~
~~b. A description of how the Patient or Personal Representative may complain to TCHD (including the name or title and phone number of the Privacy Officer) or to the Secretary of the Department of Health and Human Services.~~
~~c. If applicable, an explanation of the Patient's or Personal Representative's review rights and how to pursue those rights.~~

F. **REFERENCES:**

1. California Health and Safety Code Section 123100, et seq.

2. 45 Code of Federal Regulations (CFR) 164.501
3. 45 CFR 164.524
~~3.~~**4. 45 CFR 164.526**
~~4. TCHD Privacy: Designated Record Set Policy #8610-514~~
~~5. TCHD Use and Disclosure of Protected Health Information: Records Policy #8610-515~~
~~6.~~**5.** TCHD Verification of Identity and Authority of Persons Requesting PHI, including Personal Representatives Policy #8610-593

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
COMPLIANCE

ISSUE DATE: 01/03 **SUBJECT:** Amendment to Protected Health Information

REVISION DATE: 04/03, 12/05, 02/09, 06/15 **POLICY NUMBER:** 8610-520

Administrative Content Expert:	**06/20**
Administrative Policies & Procedures Committee Approval:	**~~05/15~~07/20**
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**06/15**

A. **PURPOSE**:

1. To establish ~~the mechanism for patients to request amendments to their health information in the medical record if they believe his/her information is inaccurate, incomplete, or incorrect~~ **a means by which an individual can amend his or her protected health information (PHI) or a record about the individual in his or her designated record set.**

B. **DEFINITIONS**:

~~2.~~**1.** Business Associate: **A** ~~a~~ person or organization who, on behalf of Tri-City HealthCare District (TCHD), performs certain functions or activities or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of the TCHD or where ~~the District~~**TCHD** needs to **d**~~D~~isclos~~ure~~ PHI to Business Associate for the services.

~~3.~~**2.** Designated Record Set: **T**~~t~~hose documents, whether maintained in paper, film or electronic formats, that comprise the Individual's medical record as approved by the Medical Executive Committee, that comprise the Individual's billing records, and any documents used in whole or in part by TCHD to make decisions about individuals including copies from another health care provider's designated record set.

3. **Patient**~~Individual~~: **T**~~t~~he person who is the subject of protected health **information (PHI).**

4. **Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in electronic and/or other format that is created or received by TCHD, and**

- **a. Relates to the past, present, or future physical or mental health or condition of an individual; or**
- **b. Relates to the provision of health care to an individual; or**
- **c. Relates to the past, present, or future payment; and**
- ~~1.~~**d. Identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual.**

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

1. ~~TCHD shall respond to patients' requests for amendments to their health information in accordance with HIPAA requirements~~**An Patient**~~Individual~~ **has the right to request to have TCHD amend PHI or a record about the** ~~Individual~~**Patient in a Designated Record Set for as long as the PHI is maintained in the Designated Record Set by TCHD.**
2. ~~Patients Individual~~**Patients** shall submit requests for amendment in writing and provide a reason to support the requested amendment.
3. **TCHD has 30 days to respond to the** ~~Individual~~**Patient of the acceptance, partial acceptance or denial of the request. If TCHD is not able to respond within this timeframe,**

TCHD may have up to an additional 30 calendar days, as long as it provides the ~~Individual~~Patient – within that initial 30-day period – with (1) a written statement of the reasons for the delay and (2) the date by which TCHD will complete its action on the request.

~~2.~~

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

1. ~~Adult patients and emancipated minors have the right to request an amendment to their Protected Health Information (PHI) created by TCHD at any time while the organization maintains the information.~~**The ~~Individual~~Patient will be directed to the Health~~care~~ Information ~~and~~ Management ~~(HIM)~~ ~~d~~Department (HIM) to complete the Request for Amendment form. The ~~Individual~~Patient must:**
   - a. **State the portion of the record to be amended,**
   - b. **Specify how it should be amended; and**
   - ~~1.~~c. **Identify the Author who originated the portion to be amended.**

~~2. TCHD will provide notification of agreement or denial of the patient's request no later than 60 days from receipt of the request. One 30-day extension may be obtained.~~ ~~**he HIM department representative will forward the request to the Compliance/Privacy Officer for review and processing.**~~

~~3.~~2. ~~Direct all patients who request to make an amendment to their health record to the Medical Records/Health Information Department~~**The HIM Director, or designee, will contact the author to review and evaluate the request for amendment.**

~~4.~~3. ~~Notify patients that their request must:~~**If the request for amendment is accepted by the author, the PHI will be amended and the ~~Individual~~Patient will be informed of the amendment within 60 days of the written request.**

~~a. Be submitted in writing; provide form (Request to Amend Protected Health Information).~~
~~b. Written addendum added to their record is limited to 250 words or less.~~
~~c. Include a reason for the requested amendment.~~
~~d. Identify others who patient believes need the amendment.~~

~~5.~~4. ~~To obtain a 30-day extension for the TCHD response to a requested amendment, Medical Records Director/Privacy Officer will notify patients, within 60 days of their amendment request via the Response to Request to Amend Protected Health Information letter:~~**The HIM ~~W~~will obtain the ~~Individual~~Patient's authorization to send the amendment to those identified by the ~~Individual~~Patient.**

~~a. TCHD's need for a 30-day extension for responding to their request.~~
~~b. Reason for extension.~~
~~c. Date by which request will be processed.~~

~~4.~~5. ~~The Medical Records/Health Information Department may coordinate review of submitted amendment request with legal counsel. The physician or clinical staff involved may be consulted on the request to:~~**If the request for amendment is denied by the author, the ~~individual~~Patient will be notified within 60 days of the written request. A copy of the denial will be placed in the Designated Record Set.**

~~d. Determine impact on care of the patient.~~
~~e. Identify Business Associates who may have relied or could potentially rely on the amended information to the detriment of the patient.~~
~~f.~~a. ~~Provide a recommendation for agreement or denial of requested amendment.~~

E. AMENDING THE PHI:

~~g.~~1. **The author who agrees or partially agrees with the request shall indicate in the Designated Record Set that "Per the patient's request, the record is amended as follows", and make the appropriate changes.**

F. DENIAL OF AMENDMENT REQUEST:

1. **If the amendment is denied by the author, TCHD will notify the ~~Individual~~Patient within 60 days of the written request. The denial will:**
   - a. **State the reason for the denial**

b. Inform the ~~Individual~~Patient that he or she may submit a written reply disagreeing with the denial.
c. Provide the ~~Individual~~Patient information on how to submit a reply to the author.
d. State that TCHD may provide a written rebuttal to the ~~Individual~~Patient's statement of disagreement.
e. Inform the ~~Individual~~Patient that he or she can request that the denial and original request for the amendment be included in all future inquiries regarding the ~~Individual~~Patient's medical information.

2. When TCHD is in receipt of notification of amendment from another healthcare provider that an ~~Individual~~Patient's PHI has been amended, the following steps will be taken:
a. The amendment and notification will be appended to the ~~Individual~~Patient's Designated Record Set.
b. TCHD will inform its Business Associates that may use or rely on that ~~Individual~~Patient's PHI of the amendment so that they may make the necessary revisions based on the amendment.

~~7. Agreement with requested amendment~~
~~i. Director of Medical Records/Privacy Officer will notify patient of agreement for their request via the Response to Request to Amend Protected Health Information letter.~~
~~ii. Request that the patient identify others who they believe need the amendment, and for permission to send the amendment to those identified.~~
~~1. The Notification of Amendment to Protected Health Information is to be completed and sent to all parties identified by the patient for which permission has been obtained.~~
~~iii. Identify all portions of the medical record that are the subject of the accepted amendment.~~
~~iv. Add the amendment to the medical record. Corrections may be documented by drawing a line through the incorrect information, recording the correct information and recording your name and date next to the change.~~
~~v. Obtain Authorization from the patient for release of information to each Business Associate identified by the patient.~~
~~b. Denial of requested amendment~~
~~i. Document reason for denial of the request for amendment via the Response to Request to amend Protected Health Information letter:~~
~~1. A reason was not included to support patient's request.~~
~~2. PHI in the medical record is accurate and complete based upon review completed within the Medical Center.~~
~~3. PHI was not created by TCHD, unless the Individual~~**Patient** ~~provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.~~
~~4. PHI is not part of the Designated Record Set.~~
~~5. Would not be available under Federal/State law to the patient for inspection (i.e. psychotherapy notes).~~
~~ii. Consult with the Legal Services Department regarding written notice of denial to the patient. TCHD shall provide a timely, written denial to the patient which shall include:~~
~~1. Basis for denial may file the statement;~~
~~2. Patient's right to submit a written statement that, if the patient does not submit a written statement disagreeing with the denial and how the patient may file the statement;~~
~~3. A statement that, if the patient does not submit a statement, the patient may request that TCHD provide the patient's request for amendment and the denial with any further disclosures of PHI that is subject of the amendment;~~
~~4. A description of how the patient may complain to TCHD or the Secretary pursuant to the complaint procedures (including the name or title and telephone number of the contact person or designated office). to prepare~~

written notice to the patient to include basis for denial.

iii. Inform the patient that they have the right to resubmit disagreement with the denial at which time a rebuttal statement must be provided to the patient. (Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures form).

iv. TCHD may provide a written rebuttal to the patient's statement of disagreement. In such cases, TCHD shall provide a copy of the rebuttal to the patient who submitted the statement of disagreement.

c. Amendments added to the health record will be included in disclosures of health information to any third party. In addition, include the communications of corrections, denial, rebuttals, etc. with all future disclosures.

i. If a statement of disagreement has been submitted by the patient, TCHD must include the material appended or, at the election of TCHD, an accurate summary of any such information, with any subsequent disclosure of the PHI to which the disagreement relates.

ii. If the patient has not submitted a written statement of disagreement, TCHD must include the patient's request for amendment and its denial, or an accurate summary of such information with any subsequent disclosure of PHI only if the patient has requested such action.

iii. When a subsequent disclosure is made with respect to 9a or 9b, using a standard transaction that does not permit the additional material to be included with the disclosure, TCHD may separately transmit the material to the recipient of the standard transaction.

iv. Amendment communications are scanned to the electronic health record to the encounter to which the amendment applies.

v. Medical Records/Health Information Release of Information team members must include this information when complying with future requests for release of records if as required above.

d. Receipt of information in the addendum that contains defamatory or otherwise unlawful language, and the inclusion of that language in the record shall not, in and of itself, subject the health care provider to liability in any civil, criminal, administrative or other proceeding.

e. When TCHD is in receipt of notification of amendment from another health care provider that a patient's PHI has been amended the following steps will be taken:

i. The amendment and notification will be appended to the patient's medical record.

ii. TCHD will inform its business associates that may use or rely on that patient's PHI of the amendment so that they may make the necessary revisions based on the amendment.

f. Verbal requests to correct/amend financial or demographic data will be accepted. Completion of the Request to Amend Protected Health Information form will not be necessary.

G. **REFERENCES:**

~~g.~~**a.** California Health & Safety Code § 123111

~~h.~~**b.** 42 Code Federal Regulations (CFR) Section 164.306

~~i.~~**c.** 42 CFR Section 164.530

~~j.~~**d.** 42 CFR Section 164.526

~~k.~~**e.** 42 CFR Section 160.103

~~l.~~**f.** Administrative Policy – Compliance Privacy: Designated Record Set 8610-514

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 5/03

SUBJECT: Use and Disclosure of PHI for Marketing

REVISION DATE: 1/06; 7/06; 4/09, 05/16

POLICY NUMBER: 8610-523

Administrative Content Expert~~Department~~ Approval ~~Date~~:	**~~03/16~~06/20**
Administrative Policies & Procedures Committee Approval:	**~~04/16~~07/20**
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval:	**~~05/16~~ n/a**
Board of Directors Approval:	**05/16**

A. **PURPOSE:**

1. The purpose of this Policy is to provide guidance on the Use and Disclosure of Protected Health Information (PHI) for purposes of marketing including the requirement to obtain patient Authorizations for such marketing.

B. **DEFINITIONS:**

1. Authorization: **T**~~t~~he written form that complies with HIPAA in order to ~~Use~~ **use** and ~~Disclose~~ **disclose** PHI for Marketing.
2. Disclosure: ~~t~~**T**he release, transfer, provision of, access to or divulging of PHI outside TCHD.
3. Financial Remuneration: **D**~~d~~irect or indirect payment to TCHD from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include payment for the treatment of a patient.
4. **Patient**~~Individual~~: **A**~~a~~s used in this Policy is the person who is the focus of the PHI.
5. Marketing: **A**~~a~~ny communication about a product or service that encourages the purchase or use of the product or service. ~~Marketing does not include those activities that are expressly excepted as provided in this Policy.~~**Use (but not disclosure) of PHI for purposes of making the following communications is excluded from the definition of marketing and therefore not subject to the individsual written authorization requirement, provided that TCHD does not receive any direct or indirect re~~num~~muneration or economic benefit from the third party for that communication.**
   - **a. A communication made to provide refill reminders or otherwise communicate about a currently prescribed drug or biological; or**
   - **b. A communication made for specific treatment and health care operations purposes, this includes communications made:**
     - **i. For treatment of an ~~individual~~Patient by a health care provider, including case management or care coordination, or to order or recommend alternative treatments, therapies, providers or settings of care;**
     - **ii. To describe a health-related product or service, or payment for such product or services, TCHD provides or is included in its benefits plan (e.g. information regarding the entities participating in a health care provider network or health plan network);**
     - **~~1.~~iii. For case management or care coordination, providing information about treatment alternatives or other related functions that do not fall within the definition of treatment.**
     - **~~i.~~iv. ~~If~~ a particular use (not ~~not~~ disclosure) of PHI meets definition of marketing and does not fall within any of the above exclusions from the definition, then such use may nonetheless be permissible without an**

~~indivusalsindividual~~Patient's written authorization if it falls into one of the following exceptions to the ~~individual~~Patient authorization requirement:

1) **A face-to-face communication by a covered entitiy to an ~~individual~~Patient;~~b.~~**
2) **A promotional gift of nominal value provided by a covered entity.**

6. Remuneration **~~Renumeration m~~Means direct or indirect payment from or on behalf of a third party whose product or service is is being described.**

~~5.~~**7.** Personal Health Information (PHI): ~~I~~Individually identifiable health transmitted or maintained in paper or electronic form that is created or received by TCHD AND

a. Relates to the past, present, or future physical or mental health or condition of an ~~individual~~**Patient**; OR
b. Relates to the provision of health care to an ~~individual~~**Patient**; OR
c. Relates to the past, present, or future payment, AND
d. Identifies the ~~individual~~**Patient** OR with respect to which there is a reasonable basis to believe the information can be used to identify the ~~individual~~**Patient**.

~~6.~~**8.** Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.

C. **POLICIES:**

1. Valid Authorizations are required for the Use or Disclosure of a patient's PHI for Marketing unless this Policy expressly permits Marketing without an Authorization or the activity is not included in the definition of Marketing.
2. If the Marketing activity involves Financial Remuneration to TCHD from a third party, an Authorization must be obtained and the Authorization must also state that Financial Remuneration is involved.

D. **PROCEDURES:**

1. Marketing: Uses and Disclosures Requiring Authorizations
   a. TCHD employees shall obtain a valid Authorization for the Use or Disclosure of a patient's PHI for Marketing unless this Policy expressly permits Marketing without an Authorization or the activity is not included in the definition of Marketing as discussed below.
   b. If no exception applies, and the Marketing involves direct or indirect Financial Remuneration or economic benefit to TCHD from a third party, TCHD must obtain an Authorization and the Authorization form:
      i. Must meet the requirements for a valid Authorization
      ii. Must contain the name or the other specific identification of the persons, or class or persons, to whom TCHD may make the authorized Use or~~f~~ Disclosure. A blanket authorization for Marketing is not permitted.
      iii. Must state that Financial Remuneration is involved.
      iv. Must be reviewed and approved in advance by the Chief Marketing Officer and the Chief Compliance **and Privacy** Officer, with the assistance of ~~legal~~ **general** counsel, as necessary and appropriate.
   c. PHI includes demographic information, without any accompanying diagnosis or treatment information, so if no exception applies an Authorization must be obtained from the patient even to use the patient's address or phone number for Marketing.
2. Marketing: Uses and Disclosures Permitted Without an Authorization
   a. The following communications are permitted under this Policy without a patient Authorization:
      i. TCHD may make a face-to-face marketing communication, as long as TCHD does not receive any Financial Remuneration or economic benefit, direct or indirect, from a third party for the communication.
      ii. TCHD may provide
         1) "Promotional gifts" of nominal value as long as TCHD does not receive Financial Remuneration from a third party. Such "promotional gifts" must be limited to items of nominal value (i.e. less than $10) such as pens,

refrigerator magnets, memo pads and/or key chains containing TCHD's name. Promotional gifts may not include cash or cash equivalents (e.g. gift cards). Any other proposed "promotional gifts" or those that exceed nominal value must be reviewed and approved in advance by the Chief Marketing Officer and the Chief Compliance **and Privacy** Officer, with assistance of ~~legal~~ **general** counsel, as necessary and appropriate.

3. Marketing: Communications that are not Considered Marketing and Do Not Require an Authorization
   a. Marketing activities that do not use PHI are not subject to HIPAA. Example: a third-party purchased consumer list used to send information about a healthcare provider to a certain segment of the general population (For example, all men under 50, and living in the 60606 zip code) would not fall under HIPAA.
   b. TCHD is not required to obtain patient Authorization for the following activities when TCHD does not receive Financial Remuneration or economic benefit from a third party:
      i. Communications that may be part of TC**HD's**~~MC's~~ treatment of an ~~Individual~~**Patient** and health care operations, including case management, care coordination, even if sale or use of a product or service is promoted.
      ii. Communications that may be part of TCHD's treatment of an ~~Individual~~**Patient** including to direct or recommend alternative treatment, therapies, referrals to other providers, care settings for an ~~Individual~~**Patient**.
      iii. Communications describing the availability of more cost effective pharmaceuticals.
         1) Example: recommending a specific over-the-counter cough medication to a patient with high blood pressure.
      iv. Communications for case management or care coordination activities and related functions to the extent they do not fall under treatment.
   c. TCHD may make the following communications to enrollees of health plans (i.e. HMO's) when TCHD does not receive Financial Remuneration or economic benefit from a third party:
      i. Communications made solely for the purpose of describing its participation in a provider network of the licensed health plan to which the enrollees already subscribe; or
      ii. Communications made solely for the purpose of describing if, and the extent to which, it provides a product or service included in a plan of benefits of a licensed health plan to which the enrollees already subscribe.
4. Marketing Representations
   a. TCHD marketing communications and materials will be reviewed to ensure that they are free from exaggeration and do not use fear tactics as a means of persuasion and that they are a factual representation of TCHD's services.

E. **RELATED POLICIES:**
1. TCHD Administrative Policy # 518 Notice of Privacy Practices
2. TCHD Administrative Policy # 525 Use and Disclosure of PHI for Fundraising

F. **REFERENCES:**
1. 45 CFR Section 164.501
2. 45 CFR Section 164.508(a)(3)
3. Cal. Civil Code Section 56.10(d)

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 4/03

SUBJECT: Facility Directory & Visiting Guidelines for Clergy

REVISION DATE: 1/06; 01/09; 03/11, 12/15

POLICY NUMBER: 8610-527

Administrative Content Expert:	**06/20**
Administrative Policies & Procedures Committee Approval:	**~~10/15~~07/20**
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	**~~11/15~~ n/a**
Board of Directors Approval:	**12/15**

A. **PURPOSE:**

1. To establish policy for the Use and Disclosure of Protected Health Information ~~(PHI)~~ to the clergy and to define guidelines for visiting clergy.

B. **DEFINITIONS:**

1. Disclosure: **T**~~t~~he release, transfer, provision of access to, or divulging in any other manner of information outside ~~the entity holding the information~~**Tri-City Healthcare District (TCHD)**.
2. Protected Health Information (PHI): ~~individually~~ **Individually** identifiable health information transmitted or maintained in paper or electronic form that is created or received by ~~Tri-City Healthcare District (~~TCHD~~)~~ ~~AND~~**and**
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment;~~,~~ ~~AND~~**and**
   d. Identifies the individual ~~OR~~ **or** with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
3. Research: **A**~~a~~ systematic investigation including research development, testing and evaluation designed to develop or contribute to generalizable knowledge.
4. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.

C. **POLICY:**

1. TCHD may **u**~~U~~se and **d**~~D~~isclose patient directory information to clergy where patients have been informed of such Use and Disclosure and have not objected or restricted such Use and Disclosure.

D. **PROCEDURES:**

1. Disclosure of PHI
   a. In accordance with Health Insurance Portability and Accountability Act (HIPAA), clergy, including Eucharistic Ministers, may have access to a subset of PHI for all patients who have not opted out of the facility directory for purposes of hospital visits.
   b. Clergy will be able to checkout from the ED Registration (Sat/Sun) ~~and~~ **or** the **i**~~I~~nformation-**d**~~D~~esk (Monday thru Friday)~~-~~ a list of patients (who have not objected or restricted **D**~~D~~isclosure to clergy) from the facility directory only for their specific religious affiliation if they have a badge. A TCHD badge will be required for all clergy requesting a list of patients.
   c. The facility directory may include the following limited information:
      i. The patient's name

ii. Location in the hospital
iii. General health conditions (that does not communicate specific medical information about the patient) and
iv. Religious affiliation

d. Registrars in the Admitting/Registration department will print, **up**on request, the list of patients for the clergy person's religious affiliation for the **i~~I~~**nformation **d~~D~~**esk.

e. ED Registration will generate the listing on weekends at 7am which will be available to be checked out.

f. When the clergy person is finished with the list, they must return it to the **i~~I~~**nformation **d~~D~~**esk (Mon thru Fri) ~~and~~ **or** ED Registration (Sat/Sun) where it will be logged in.
i. The patient listing will be ~~-~~disposed of in the confidential bin. In no case~~s~~ is the list to leave TCHD premises.

g. The Director of the Chaplains or his/her designee will have access to all patients in the facility directory.

h. The Director of the Chaplains will ~~review the daily logs for confirmation that all have been received and will~~ follow-up on any non-compliance with ~~TCMC~~ **TCHD** procedures. ~~Clergy Logs will be maintained for a period of one week.~~

2. Guidelines for **V~~v~~**isiting **C**~~c~~lergy

a. Community clergy and religious lay visitors are guided by the same policy as all visitors.

b. It is expected that both clergy and lay visitors confine their visits in their official capacity to the members of their own congregation or group.

c. ~~The Hospital~~**TCHD** assists patients to observe the rites and practices of their religious groups in order to receive spiritual support and enhance their basic well-being.
i. Rites and sacraments, such as baptism, communion, confession and the sacrament of the sick, should be given only at the patient's or the family's expressed wish, and should be administered by the patient's clergy in accordance with the patient's denomination or affiliation.
ii. Staff in their various departments will cooperate with patients who wish to participate in religious rites and observances, with the exception of anything in the attending physician's or nurse's view, would be detrimental to the patient.
iii. ~~Patients~~ **Clergy** and those who administer such rites and sacraments are expected to cooperate with staff by coordinating their ministry with the other demands of the patient's treatment.

~~E. FORM REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~
~~1. Clergy Log~~

~~F.~~E. REFERENCES:

1. 42 CFR section 164.510 (a) (1)
~~1.~~**2. Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Date: _____

Tri-City Medical Center

Clergy Log

Name of Clergy	Religious Affiliation	Time list logged out	Time list returne

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 4/03

SUBJECT: Accounting of Disclosures of Protected Health Information (PHI)

REVISION DATE: 02/09, 06/15

POLICY NUMBER: 8610-528

Administrative Content Expert:	**06/20**
Administrative Policies & Procedures Committee Approval:	**~~05/15~~07/20**
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit and Compliance Committee Approval:	**~~06/15~~ n/a**
Board of Directors Approval:	**06/15**

A. **PURPOSE:**

1. To **provide a means for patients to request** ~~outline steps to be taken when a patient exercises his or her right~~ **~~under the Health Insurance Portability and Accountability Act ("HIPAA")~~** ~~to request~~ an ~~accounting~~ **Accounting** of Disclosures made regarding **their** Protected Health Information.

B. **DEFINITIONS:**

1. Disclosure: ~~—T~~the release, transfer, provision of, access to, or divulging in any other manner of information outside ~~the entity holding the information~~**Tri-City Healthcare District (TCHD)**.
2. **Patient**~~Individual:~~ **T**~~t~~he person who is the subject of protected health **information**~~iton~~.
3. Limited Data Set: ~~I~~**i**~~s~~ information that may be **d**~~D~~isclosed to an outside party without a patient's authorization. ~~if certain conditions are met as provided by Health Insurance Portability and Accountability Act (HIPAA).~~**HIPAA Privacy Rule.**
4. Protected Health Information ("PHI"): ~~i~~**I**ndividually identifiable health **information** transmitted or maintained in paper, ~~or~~ electronic **or** other form that is created or received by ~~TCMC~~ **TCHD** ~~AND~~ **and**
   a. Relates to the past, present, or future physical or mental health or condition of an ~~individual~~**Patient**; ~~OR~~**or**
   b. Relates to the provision of health care to an ~~individual~~**Patient**; ~~OR~~**or**
   c. Relates to the past, present, or future payment;~~,~~ ~~AND~~**and**
   d. Identifies the ~~individual~~**Patient** ~~OR~~ **or** with respect to which there is a reasonable basis to believe the information can be used to identify the **i**~~I~~ndividual.
5. Research: ~~A~~**a** systematic investigation including research development, testing and evaluation designed to develop or contribute to generalizable knowledge.

C. **POLICY:**

1. **~~An individual~~Patient has a right to receive an accounting of disclosures of PHI made by a covered entity in the six (6) years prior to the date on which the accounting is requested,~~;~~ except for the following disclosures~~.~~:**
   a. **To carry out treatment, payment and health-care operations**
   b. **To individuals of PHI about them**
   c. **Pursuant to an authorization**
   d. **For the facility's directory or to persons involved in the ~~i~~individual's care or other notification purposes**
   e. **For national security or intelligence purposes**
   f. **To correctional institutions or law enforcement agencies that have lawful custody of an inmate**

g. **As part of a limited data set**
h. **That occurred prior to the compliance date for the covered entity; or**
i. **Incident to a use or disclosure otherwise permitted or required**

~~1. Tri-City Healthcare District ("TCHD") must furnish, upon request by the Individual who is the subject of the Protected Health Information (PHI),~~**PHI,** ~~an accounting of certain Disclosures of the Individual's PHI made by it and its Business Associates in the six years prior to the date on which the accounting is requested.~~

~~2. Patients have a right to an accounting of Disclosures of PHI except where not required by HIPAA as described as accepted by HIPAA. TCHD shall provide the Individual with the written accounting in the time and manner required by HIPAA as described in this Policy.~~

~~3.~~**2.** TCHD is required **to track the Ddisclosures of ~~Iindividual~~ Patient PHI as listed below** ~~to provide an accounting of Disclosures including related to the following Disclosures~~:

a. **Required by law**
b. **Public health activities**
c. **Victims of abuse, neglect, or domestic violence unless the Covered Entity (CE), in exercising professional judgment, believes informing the ~~individual~~ Patient may cause serious harm or if the CE believes the Patient~~individual~~ is responsible for the abuse, neglect, or injury.**
d. **Health oversight activities**
e. **Judicial and administrative proceedings**
f. **Law enforcement purposes**
g. **Decedents:**
    i. **Coroners and medical examiners**
    ii. **Funeral directors**
h. **Cadaveric organ, eye, or tissue donation purposes**
i. **Research purposes where a waiver of authorization was provided by the Institutional Review Board or Privacy Board, preparatory reviews for research purposes and/or research on decedent's information**
j. **In order to avert a serious threat to health or safety**
k. **Specialized government functions:**
l. **Military and veterans activities**
m. **Protective services for the President and others**
n. **Worker's compensation disclosures necessary to comply with laws relating to worker's compensation programs (not including disclosures related to payment).**
o. **Inappropriate disclosures (e.g., the incorrect PHI being provided to the wrong patient, the incorrect PHI being provided to an attorney)**

~~a. To the Secretary of Health and Human Services for compliance investigation purposes.~~
~~b. Disclosures not permitted by law or authorized by patient (i.e. Unintentional Disclosures).~~
~~c. Related to child abuse, neglect, or domestic violence.~~
~~d. For judicial and administrative proceedings.~~
~~e. For law enforcement purposes (this entity may request that we delay Disclosure).~~
~~f. For certain public health activities including:~~
    ~~i. Disclosures for the purpose of preventing or controlling disease.~~
    ~~ii. Disclosures related to victims of child abuse or neglect.~~
~~g. Related to Hhealth oversight activities.~~
~~h. About decedents.~~
~~i. For purposes of cadaver organ donation.~~
~~j. For research we are allowed to conduct without a patient's authorization.~~
~~k. To avert a serious threat to health or safety.~~
~~l. For specialized government functions.~~
~~m. To correctional institutions.~~
~~n. For worker's compensation.~~

~~c. For certain marketing and fundraising exceptions.~~

~~4. TCHD is not required to provide an accounting for the following types of Disclosures:~~

~~a. To the individual or patient representative.~~

~~b. To carry out treatment, payment, and healthcare operations.~~

~~c. Pursuant to an authorization of the individual.~~

~~d. With patient's verbal agreement to:~~

~~i. Include information in facility directory~~

~~ii. Disclose information to:~~

~~1) Next of kin~~

~~2) Personal friend~~

~~3) Person involved in individual's care~~

~~e. Incidental to a permitted use or Disclosure.~~

~~f. For national security or intelligence purposes.~~

~~g. To correctional institutions or law enforcement officials.~~

~~h. Disclosures made prior to the compliance date.~~

~~i. As part of a Limited Data Set (LDS).~~

D. **PROCEDURES:**

1. Timeframe for Providing Accounting of Disclosures
   a. TCHD must act on a request for an accounting of Disclosures no later than 60 days from the date that the request is received.
   b. If TCHD is unable to comply within 60 days, **a one time only,** ~~the deadline can be~~ extent**ion of** ~~ded by~~ 30 days **can be granted, provided that:**
      i. The ~~the~~ **request is within the time period of the initial 60 days of the received request**
      ii. TCHD p~~P~~**rovides a statement to the** ~~individual~~ **Patient as to the** ~~however, TCHD is obligated to state in writing to the requestor the~~ reason for the delay
      ~~b.~~**iii.** ~~Proivde~~**TCHD provides the date the disclosure will be made.** ~~, and the day by which TCHD will fulfill the request.~~
   ~~c. Information to be included will reflect Disclosures made for the last six (6) years beginning April 14, 2003.~~
2. Required Content of Accounting of Disclosures
   a. TCHD **must include the information below for each D**~~d~~**isclosure**~~will provide the following information for each accounting~~:
      i. The date of the Disclosure.
      ii. The name of the entity or person that received the PHI and, if known, the address of such person or entity.
      iii. A brief description of the PHI ~~D~~**d**isclosed.
      iv. A brief statement of the purpose of the Disclosure that reasonably informs the ~~individual~~**Patient** of the basis for the Disclosure; or in lieu of such a statement:
         1) A copy of the ~~individual~~**Patient**'s written authorization **or** ~~for the Disclosure OR~~
         2) A copy of the written request for a Disclosure permitted under the Privacy Rule, if any.
3. How to Respond to ~~Request~~ **Rrequest** for Accounting of Recurring Disclosures
   a. If, during the period covered by the accounting, TCHD has made multiple Disclosures of PHI to the same person or entity for a single **purpose,** ~~purpose related to investigations or compliance with the Privacy Rule, under the public policy Disclosures (that do not require consent or authorization), pursuant to or a single authorization from the Individual, TCHD may satisfy~~ the accounting **may, with respect to** ~~requirement for~~ **such** multiple Disclosures, ~~by~~ provid**eing**:
      i. The date of the first Disclosure during the accounting period.
      ii. The frequency, periodicity, or number of the D~~d~~**isclosures made during the**

accounting period

~~i.~~**iii.** **The date of the last such D~~d~~isclosure during the accounting period.**

~~ii.~~**iv.** The name of the entity or person that received the PHI and if known, the address of such person or entity.

~~iii.~~**v.** A brief description of the PHI d~~D~~isclosed.

~~iv.~~**vi.** A brief statement of the purpose of the Disclosure that reasonably informs the ~~individual~~**Patient** of the basis for the Disclosure; or in lieu of such a statement:

1) A copy of the **Patient**~~Individual~~'s written authorization for the Disclosure ~~OR~~**or**
2) A copy of the written request for a Disclosure permitted under the Privacy Rule, if any.

~~v. The frequency, periodicity or number of Disclosures made during the accounting period.~~

~~vi. The date of the last such Disclosure during the accounting period.~~

4. Disclosures of PHI for Research **P**~~p~~urposes

a. TCHD, if~~,~~ during the period covered by the accounting, has disclosed PHI for a research project where 50 or more individuals have been included, must provide:

~~a. The accounting will be referenced to a specific IRB protocol with reference to the patient to notify the Privacy Officer for specific information relating to the protocol.~~

b. ~~Information relating to the protocol must include the following and will be prepared by the Research Coordinator:~~

i. Name of the protocol **or other research activities**~~.~~

ii. Description **of the research protocol or other research activity, including the** ~~and~~ purpose of ~~Research~~ **the research** and **the** criteria used for selecting particular records.

~~iii. A b~~**B**rief description of type of PHI ~~D~~**d**isclosed ~~as part of the Research.~~

~~iv.~~**iii.** Date or period of time during with Disclosure(s) occurred, **or may have occurred,** including date of last Disclosure during accounting period.

~~v.~~**iv.** Name, address, telephone number of entity that sponsored the ~~Research~~ **research** and of the researcher to whom the information was disclosed.

~~vi.~~**v.** Statement the PHI of the Individual may or may not have been disclosed for a particular protocol or other ~~Research~~ **research** activity.

~~vii.~~**vi.** Offer to assist the requestor with contacting the entity that sponsored the ~~Research~~ **research** and the researcher.

5. Applicable Fees

a. The first accounting within a 12-month period will be provided free from charge.

~~a.~~**b. TCHD must notify the ~~induvial~~Individual~~Patient requesting multiple disclosures in a 12-month period of the fees that will be imposed.** ~~TCHD may not charge a fee for providing an accounting, unless the Individual makes more than one request within a 12-month period. In cases of multiple requests, the individual will be charged clerical costs of $4.00 per quarter hour plus $0.10 cents per printed page.~~

~~b.~~**c.** The patient may withdraw ~~Request~~ **the request** for an Accounting through written notification to the **Chief Compliance and** Privacy Officer.

6. ~~Maintaining a Log of~~ Accountings of Disclosures **D~~d~~ocumentation R~~r~~equirements.**

a. ~~The Privacy Rules require that T~~the following information **must** be documented by TCHD:

~~i. Information to be included in an accounting.~~

i. The written accounting that is provided to the Patient~~Individual~~

ii. ~~Accounting provided to the requesting Individua~~l.

iii. Titles of persons or ~~office~~**offices** (~~Medical Records/Health Information~~) responsible for **receiving and** processing requests for accountings ~~by Individuals~~.

iv. Individuals who complete Disclosures of PHI are required to complete ~~an~~

~~Accounting~~ **~~accounting~~** ~~of Disclosures~~ **~~disclosures~~** ~~Form~~ **~~form~~** **a Request for An Accounting of Disclosure form** and submit it to th**e Chief Compliance and Privacy Officer** ~~e Privacy Officer~~ for data entry and tracking capabilities.

E. FORMS:

1. Request for An Accounting of Disclosure

~~E.~~2. Statement of Disagreement/Request to Include Amendment and Denial With Future Disclosure

F. **REFERENCES**:

1. ~~42~~ Code of Federal Regulations ~~(CFR) Section 160.103~~

~~1.~~2. Healthcare Information Portability and Accountability Act of 1996

~~2. 42 CFR Section 164.502- 528~~

Name: _____ _____ _____
(Last) (First) (M.I.)

Address: _____

Telephone #: _____

Date of Birth: _____ **Social Security #:** _____
(Optional)

Date: _____

I would like an accounting of how my protected health information was disclosed by Tri-City Medical Center, as required by federal regulations. I understand that the Medical Center does not have to tell me the following types of disclosures:

1. Disclosures for purposes of treatment, payment and health care operations.
2. Disclosures to me.
3. Disclosures for use in the hospital's directory.
4. Disclosures to persons involved in my care.
5. For notification purposes (to notify a family member, personal representative or other person of the individual's location, general condition or death).
6. For national security or intelligence purposes.
7. To correctional institutions or law enforcement officials.
8. Disclosures made prior to April 14, 2003.

I also understand that my right to an accounting of some or all disclosures may be suspended by the government, including, but not limited to, health care oversight agencies and law enforcement officials, under limited circumstances.

I want an accounting disclosure that covers the following time period:

_____

_____

_____

(Note: the time period must be no longer than six years prior to the date of this request and may not include dates before April 14 2003)

Tri-City Medical Center
ADVANCED HEALTH CARE FOR YOU
4002 Vista Way, Oceanside, CA 92056

REQUEST FOR AN ACCOUNTING OF DISCLOSURE

Request for an Accounting of Disclosures (continued)

When the accounting of disclosures is completed:

☐Please send my accounting to the following address:

_____

☐I want to pick up the accounting. Please call me at the following phone number when it is ready:

_____

I understand that the hospital must give me the accounting disclosures no later than 60 days after its receipt or inform me that it needs an extra 30 days (or less) to prepare it.

I am entitled to one free accounting of disclosures in any 12-month period. I understand that additional accountings will cost $ ____ each.

Signature of patient or representative: _____

If representative, give relationship: _____

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at tricitymed.org or at our Medical Records/Health Information Department at Tri-City Medical Center or by sending a written request to our Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

To file a complaint with the Medical Center, contact our Privacy Officer at:
Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Privacy Officer
Values Line Phone: (844) 521-7862
https://tchd.ethicspoint.com

Name: _____ _____ _____
(Last) (First) (M.I.)

Address: _____

Telephone #: _____

Date of Birth: _____ **Social Security #:** _____
(Optional)

Date: _____

I understand that Tri-City Medical Center denied my request to amend (change) my protected health information. My request was date: _____

Mark only one box below:

☐I want to file this "Statement of Disagreement." I agree with the denial because:

_____

_____

I understand that the hospital may prepare a written rebuttal to my Statement of Disagreement. A "rebuttal" is a statement of why the hospital thinks my Statement of Disagreement is wrong. If the hospital prepares a written rebuttal, I will receive a copy.

☐I do not want to file a "Statement of Disagreement" but I want Tri-City Medical Center to include my amendment (change) request and the denial along with any future disclosures of the protected health information subject to my amendment request.

Signature of patient or representative: _____

If representative, give relationship: _____

For more information about your privacy rights, see the "Notice of Privacy Practices" available on our website at tricitymed.org or at our Medical Records/Health Information Department at Tri-City Medical Center or by sending a written request to our Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with the Medical Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

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Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
COMPLIANCE

ISSUE DATE: 5/04

SUBJECT: Notification to Pre-Hospital Personnel; Exposure to Infectious Disease

REVISION DATE: 7/04; 12/05; 06/09

POLICY NUMBER: 8610-530

Administrative Content Expert~~Department~~ Approval:	**~~10/16~~05/20**
Administrative Policies & Procedures Committee Approval:	**~~10/16~~05/20**
Organization Compliance Committee Approval:	**~~11/16~~09/20**
Medical Executive Committee Approval:	**01/17**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval:	**~~03/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **PURPOSE:**

1. Both federal and California law establish requirements for reporting exposures of pre-hospital emergency medical personnel to certain infectious diseases.

B. **DEFINITIONS:**

1. Pre-hospital emergency medical care personnel may include: Paramedic, Registered Nurse (RN), Emergency Medical Technician (EMT), lifeguard, fire fighters, peace officers, federal officers, volunteers, and physicians who provide pre-hospital emergency medical care or rescue services.
2. Reportable disease or condition means those diseases listed in Section I and prescribed by Title 17, CCR Sections 2500-2640 and Title 8, CCR Section 5199 Appendix A.
3. Mobile Intensive Care Nurse (MICN): a Registered Nurse specialized in pre-hospital care. The MICN works with medics, EMTs, and pre-hospital staff to provide patient care while following San Diego protocols.

C. **CALIFORNIA REPORTING LAW:**

1. Under specified circumstances, pre-hospital emergency medical care personnel exposed to a person afflicted with a disease or condition listed as reportable and transmitted through oral contact or secretions of the body must be notified that they have been exposed to a disease as defined in Section I [Health and Safety Code Section 1797.188
2. Notification of exposure: The pre-hospital emergency medical care person who provided services must give their name and phone number to the **Tri-City Medical Center** (TCMC) Base Hospital Coordinator (MICN) at the time patient is transferred from their care to the admitting health facility. Pre-hospital emergency medical care persons may also give their name and phone number to the transporting party to relay to the hospital.
3. The ~~Tri-City Medical Center (~~TCMC~~)~~ Base Hospital Coordinator, MICN, or Emergency Department Charge nurse facilitates the completion of the County of San Diego Communicable Disease Exposure Report. The report is then forwarded to the Infection Control department. The Base Hospital Nurse Coordinator will follow up with the EMS Coordinator/Infection Control Officer of the appropriate EMS agency. .
4. Exposed personnel arriving at TCMC are directed to Occupational Health/Emergency Department for evaluation and treatment.
5. If the exposed personnel do not arrive at TCMC, the TCMC Base Hospital Coordinator or MICN must report the name(s) and telephone number(s) to the county health officer, as soon as the patient is diagnosed with a reportable disease or condition. The phone number to call is 619-515-6620 (San Diego County Community Epidemiology Branch).

6. The County Health Officer is then responsible for informing the involved pre-hospital emergency medical care personnel of the exposure. The statute does not provide for any release of information from hospitals to pre-hospital emergency medical care personnel.
7. Furnish other pertinent information related to the occurrence as may be requested by the local health officer or CDPH.

D. **FEDERAL LAW:**

1. The Ryan White Comprehensive AIDS Resources Emergency Care Act, requires medical facilities to give a report to the "designated officer" (DO) of the pre-hospital emergency response service when personnel are exposed to specified infectious diseases (see Section I for list of diseases) during the transport of a patient to the hospital. The TCMC Base Hospital Coordinator or designee maintains a current list of facilities and designated officers.
2. The hospital is responsible for initiating reports only regarding infectious pulmonary tuberculosis. Reports regarding questions about all other infectious conditions (i.e. Hepatitis B, HIV infection (including AIDS), Diphtheria, Meningococcal disease, Plague, Hemorrhagic fevers (ex. Lassa, Marburg, Ebola, Crimean-Congo), Rabies, and others yet to be identified) will be initiated by the DO of the pre-hospital emergency response service.

E. **SCOPE OF RESPONSIBILITY:**

1. The duties of Tri-City Healthcare District terminate upon discharge of the patient for conditions arising from the emergency or at the end of the 60-day period (beginning on the date the victim is transported by the emergency response employee to the hospital), whichever period is shorter. A response must be made as soon as possible but not later than 48 hours after the request is made.
2. This time period can be extended to a maximum of 90 days if the request for information is received within 30 days of the applicable 60-day period.
3. The Ryan White Comprehensive AIDS Resources Emergency Care Act does not authorize or require a facility to test any patient for any infectious disease.
4. The Ryan White Comprehensive AIDS Resources Emergency Care Act A does not authorize or require any facility, designated officer or emergency response employee to disclose identifying information with respect to a patient or an emergency response employee.
5. The designated officer and any emergency response employee to whom disclosure is made must maintain the confidentiality of HIV test results and may be personally liable for unauthorized release of any identifying information about the HIV results.

F. **EVALUATION:**

1. TCMC receives by mail, fax, phone, or in person a request from the DO for information about possible exposure to one of the above infectious diseases.
2. These are all referred to and evaluated by the TCMC Base Coordinator.
3. After hours and on weekends, the ED "Radio Nurse" will review the request.
4. If the request is made without a Confidential Morbidity Form, one is completed by the TCMC Base Coordinator or "Radio Nurse" to gather appropriate information.
5. Infection Control can be contacted for assistance.
6. One of the following determinations is made:
   a. The pre-hospital emergency medical personnel were exposed.
   b. The pre-hospital emergency medical personnel were not exposed.
   c. Facts about the case are insufficient to determine an exposure.
7. Infection Control will notify TCMC Base Coordinator of potential exposure if a patient was transferred via ambulance/EMS.

G. **RESPONSE:**

1. All requests must be answered and shall be made in writing ASAP but no later than 48 hours after receiving the request. The response will be sent by fax whenever possible. The information provided to the DO will include the name of the infectious disease, the date the patient was transported and the run number of the EMS call.
2. If a response is sent by mail, the DO will be notified by telephone that the response has been

sent. The DO, within 10 days, must inform the facility whether the notification has been received.

3. The local public health officer will be contacted when:
   a. The hospital reviewer is unable to make an independent determination that the pre-hospital emergency medical personnel were exposed to a reportable disease or condition.
   b. The public health officer will resubmit the request to TCMC after evaluation. TCMC staff will make the follow-up report to the DO.
4. If the patient dies and a different facility is responsible for determining the cause of death, a copy of the request will be sent to that facility for the follow-up.

H. **CONFIRMED AIRBORNE DISEASES:**

1. If a patient is transported by pre-hospital emergency medical personnel to TCMC and is determined to have infectious pulmonary tuberculosis, the Infection Control Practitioner or designee will send a notice to the DO of the Emergency Medical Service that transported the patient.
2. This notice shall be made as soon as is practicable, but no later than 48 hours after a positive Mycobacterium tuberculosis culture is obtained or notification of a positive culture is received from San Diego Health and Human Services TB Control Program.
3. Notice will include the date, run number, and infectious disease involved.

I. **REPORTABLE DISEASE LIST, TITLE 17, CALIFORNIA CODE OF REGULATIONS, SECTION 2500:**

1. The following communicable diseases can be transmitted through oral contact (for example mouth to mouth respirations) or by mucus membrane or non-intact skin contact with secretions (including blood) from the patient.
   a. Acquired Immune Deficiency Syndrome (AIDS)
   b. Diphtheria
   c. Human Immunodeficiency Virus infection (HIV)
   d. Hepatitis, Viral
   e. Invasive Group A Streptococcal Infection
   f. Leprosy (Hansen Disease)
   g. Measles (Rubella)
   h. Meningococcal Infections *(Neisseria meningitidis)*
   i. Mumps
   j. Pertussis (Whooping cough)
   k. Plague, Pneumonic
   l. Poliomyelitis, Paralytic
   m. Rabies
   n. Rubella (German Measles)
   o. Tuberculosis
   p. Viral Hemorrhagic Fevers (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses)
   q. Anthrax
   r. Botulism (infant, food-borne, wound, other)
   s. Cholera
   t. Food-borne Disease
   u. Smallpox

J. **REFERENCES:**

1. California Healthcare Association Current Consent Manual
2. Title 22, California Code of Regulations, Section 70737 (General Acute Care Hospital) and 71535 (Acute Psychiatric Hospital).
3. https://www.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf
4. https://www.dir.ca.gov/title8/5199a.html
5. http://www.dir.ca.gov/title8/5199.HTML
6. Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (Ryan White Care Act, Ryan White, Pub.L. 101-381, 104 Stat. 576, enacted August 18, 1990)

7. Title 8, CCR Section 5199 Appendix A

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 6/08

SUBJECT: ~~Sanctions for~~ Non Compliance with Privacy and Security Policies & Procedures

REVISION DATE: 8/10

POLICY NUMBER: 8610-531

Administrative Content Expert:	**06/20**
Administrative Policies & Procedures Committee Approval:	**~~06/15~~07/20**
~~**Medical Executive Committee Approval:**~~	~~**07/15**~~
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit and Compliance Committee Approval:	**~~09/15~~ n/a**
Board of Directors Approval:	**09/15**

A. **PURPOSE:**

1. The purpose of this Policy is to describe the process to impose ~~sanctions~~ **disciplinary action** and/or take other corrective actions against Workforce **M**~~m~~embers~~, Medical Staff members~~ and Business Associates who fail to comply with the privacy and security policies and procedures of Tri-City Healthcare District (TCHD).

B. **DEFINITION(S):**

1. Business Associate: **A**~~a~~ person or organization who, on behalf of TCHD, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of ~~the~~ TCHD or where TCHD needs to **d**~~D~~isclose PHI to Business Associates for the services.
2. Business Associate ~~Addendum~~ **Agreement** (~~or~~ BAA): **A**~~is~~ an ~~Addendum~~ **agreement attached** to an applicable Services Agreement between ~~the District~~**TCHD** and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of ~~District~~ **TCHD** PHI.
3. Disclosure: **T**~~t~~he release, transfer, provision of, access to or divulging of PHI outside TCHD.
4. Protected Health Information (PHI): **I**~~i~~ndividually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD ~~AND~~**and**
   a. Relates to the past, present or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment;~~,~~ **and**~~AND~~
   d. Identifies the individual **or**~~OR~~ with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Services Agreement: **A**~~a~~n agreement between ~~the District~~**TCHD** and a third party whereby the third party performs a function, activity or service on behalf of ~~the District~~**TCHD**. Services Agreements that require ~~the District~~**TCHD** to **d**~~D~~isclose PHI for such functions, activities or services require **a** Business Associate A~~ddendum~~**greements**~~.~~.
6. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.
7. Workforce **Members**: **E**~~e~~mployees, **Medical Staff, Allied Health Professionals,** volunteers, trainees, **Business Visitors, Covered Contractors** 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.

C. **POLICIES:**

1. TCHD Workforce **M~~m~~**embers are required to comply with TCHD policies and procedures, including those related to patient privacy and confidentiality, as a condition of their employment. TCHD Workforce **M~~m~~**embers acknowledge compliance with these obligations as part of the TCHD Code of Conduct.
2. TCHD shall take appropriate actions to enforce TCHD's **p~~P~~**rivacy and **s~~S~~**ecurity policies and procedures as well as the underlying state and federal privacy laws and impose appropriate discipline against Workforce **M~~m~~**embers who are non-compliant with such policies and laws.
3. TCHD shall impose ~~appropriate sanctions~~ **disciplinary** ~~or take other appropriate~~ actions in the event that a ~~Medical Staff~~**Workforce M~~m~~**ember or Business Associate fails to comply with TCHD's privacy and security policies and procedures and related privacy laws when accessing, **u~~U~~**sing or **d~~D~~**isclosing TCHD patient PHI in connection with TCHD business.
4. TCHD shall document ~~the all sanctions~~ **disciplinary actions** ~~that are applied~~ for failure to comply with TCHD privacy and~~-~~ security policies~~ and~~**,** procedures and related documentation shall be retained in accordance with TCHD's Records Retention and Destruction Board Policy.

D. **PROCEDURES:**

1. Workforce **M~~m~~**embers
   a. In the event that TCHD identifies non-compliance of TCHD policies and procedures by any Workforce **M~~m~~**ember, the **Chief Compliance and** Privacy Officer and/or ~~Security Officer~~**Vice-President of IT**, as appropriate, shall confer with the Human Resources Department and Workforce **M~~m~~**ember**'s s~~S~~**upervisors to determine recommendations for appropriate discipline.
   b. TCHD may take into account the following matters when evaluating the appropriate discipline to impose in a given situation:
      i. The severity, frequency and nature of the non-compliance;
      ii. Whether the actions were intentional or unintentional and/or have been or will be reported to law enforcement for investigation of potential criminal violations;
      iii. Any prior non-compliance with privacy and/or security policies, ~~and~~ procedures and applicable laws by the same Workforce **M~~m~~**ember;
      iv. Whether the non-compliance indicates a pattern of improper access, Use or Disclosure; and/or
      v. Application of discipline to Workforce **M~~m~~**embers in a consistent manner.
   c. TCHD may impose any of the following disciplinary actions or a combination of them against Workforce **M~~m~~**embers for non-compliance with TCHD privacy and security policies and procedures:
      i. Focused education and training;
      ii. Monitoring;
      iii. Counseling;
      iv. Administrative leave;
      v. Termination; and/or
      vi. Other appropriate disciplinary actions**, as necessary.**
   d. The process for imposing ~~sanctions~~ **disciplinary actions** against Workforce **M~~m~~**embers should also take into account applicable Human Resource Department policies, collective bargaining agreements and public agency-related requirements.
   e. Recommendations for Workforce **M~~m~~**ember ~~sanctions~~ **disciplinary actions** shall be presented to **the** Vice President of Human Resources.
2. Medical Staff
   a. Medical Staff members have access to TCHD patient PHI and may be **a~~A~~**uthorized **u~~U~~**sers under TCHD **s~~S~~**ecurity policies for purposes of patient care and administrative responsibilities (see also Section 3 on Business Associates).
   b. Medical Staff must comply with TCHD's privacy and security policies and procedures and applicable laws when accessing, **u~~U~~**sing and **d~~D~~**isclosing TCHD PHI for patient care and TCHD business.
   c. In the event that TCHD identifies non-compliance of TCHD policies and procedures by any Medical Staff member, the **Chief Compliance and** Privacy Officer~~- and/or Security~~

~~Officer, as appropriate,~~ shall confer with the **head**~~Vice-President~~ **of Information Technology (IT),** Chief of Staff and/or ~~legal~~ **general** counsel to determine recommendations for appropriate ~~sanctions~~ **disciplinary actions**~~and/or other actions~~.

d. The process for imposing ~~sanctions~~ **disciplinary actions** or taking other actions against any member of the Medical Staff for non-compliance with TCHD privacy and security policies and procedures should take into account relevant requirements and conditions, if any, set forth in Medical Staff Bylaws, rules and regulations, and contractual arrangements.

3. Business Associates
   a. TCHD Business Associates may have access to TCHD PHI and/or may be **a**~~A~~uthorized **u**~~U~~sers under TCHD **s**~~S~~ecurity policies as necessary and appropriate to their contractual obligations.
   b. TCHD Business Associates must comply with TCHD's privacy and security policies and procedures and applicable laws when accessing, **u**~~U~~sing and **d**~~D~~isclosing TCHD PHI for TCHD business purposes if such access, Use and Disclosure is otherwise permitted under the Business Associate ~~Addendum~~**Agreement**.
   c. In the event that TCHD identifies non-compliance of TCHD policies ~~and~~, procedures by any Business Associate, the **Chief Compliance and** Privacy Officer and/or ~~Security Officer~~**Vice-President of IT**, as appropriate, shall confer with the Department Director and/or ~~legal~~ **general** counsel to determine recommendations for appropriate sanctions or other actions which may include, but is not limited to, removal of the Business Associate vendor, termination of the services contract and/or demands for indemnification.
   d. The process for imposing sanctions and/or taking other actions against Business Associates for non-compliance with TCHD privacy and security policies and procedures should take into account the requirements and/or conditions of the Services Agreement and Business Associate ~~Addendum~~**Agreement**.

E. RELATED DOCUMENTS:

1. **Administrative Policy 8610-631: Network Security**
2. **Administrative Policy 8610-609: Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information**
3. **TCHD Board Policy 14-0008: Records Retention and Destruction**
4. **Business Associate Agreement or Addendum**
5. **TCHD Code of Conduct**

~~E.~~F. REFERENCE ~~LISTS~~:

1. 45 Code of Federal Register (CFR) Section 160.103
2. 45 CFR Section 164.308(ii)(C)
3. 45 CFR Section 164.530(e)
4. ~~TCHD Records Retention and Destruction Board Policy #14-0008~~
5. ~~TCHD Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information Policy #8610-609~~
6. ~~TCHD Code of Conduct~~

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Education and Training; Introduction and General Policies

REVISION DATE(S): 02/16

POLICY NUMBER: 8750-545

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~10/15~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~10/15~~07/20
Organizational Compliance Committee Approval: 09/20
Administration Approval: 10/20
Audit and Compliance Committee Approval ~~Date(s)~~: ~~02/16~~ n/a
Board of Directors Approval ~~Date(s)~~: 02/16

A. **PURPOSE:**

1. To ensure that all **Tri-City Healthcare District (TCHD) Workforce Members and** Covered Contractors ~~and Volunteers (Auxiliary)~~ understand ~~the District's~~**TCHD's** commitment to compliance and the objectives and requirements of ~~Tri-City Healthcare District's (TCHD)~~ **TCHD's** Compliance Program.

B. **DEFINITIONS:**

1. Covered Contractor – A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including:
   a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and physician extenders such as physician assistants and nurse practitioners;
   b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state health care program.
2. **Workforce Members: Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors 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.**

C. **GENERAL POLICIES:**

1. Structure of Training; Trainer Qualifications.
   a. All training sessions must be designed and administered in such a way as to effectively instruct the trainees.
      i. All training sessions shall be designed to take into account the skills, experience, education level and other characteristics of the trainees.
   b. Trainers shall have sufficient knowledge and experience relative to the topic they are teaching.
      i. Trainers must be able to present the subject matter clearly.
      ii. Trainers must be able to respond to questions.
      iii. Trainers may be TCHD employees, or ~~the~~ TCHD may contract with an outside individual or entity to design and/or administer the training.
2. Supplement TCHD's Other Education and Training.
   a. The Education and Training Policies shall supplement other education and training initiatives of TCHD.

D. **QUESTIONS RELATED TO EDUCATION AND TRAINING POLICIES:**

1. Any question concerning the Education and Training Policies, or matters that are not specifically addressed in the Education and Training Policies, should be directed to ~~the~~ TCHD's Chief Compliance **and Privacy** Officer.

E. **AUDIT AND DOCUMENTATION:**

1. TCHD shall audit and document compliance with the Education and Training Policies. Such audit shall be conducted pursuant to Administrative Policy 8750-55~~23~~, Monitoring Compliance/-Auditing and Reporting – **Annual** Compliance ~~Reviews and Audits~~**Work Plan**. Relevant documentation shall be maintained in TCHD's Compliance Program files consistent with its document retention policies.

F. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-55~~23~~, Monitoring ~~Compliance~~ **Compliance/**Auditing and Reporting – **Annual** Compliance ~~Review and Audits~~**Work Plan**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Education and Training; Distribution/Certification of Code of Conduct and/or Policies

REVISION DATE(S): 02/17

POLICY NUMBER: 8750-546

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~01/17~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~01/17~~07/20
Organizational Compliance Committee: ~~01/17~~09/20
~~**Medical Executive Committee Approval:** n/a~~
Administration Approval: 10/20
Audit and Compliance Committee Approval ~~Date(s)~~: ~~02/17~~ n/a
Board of Directors Approval ~~Date(s)~~: 02/17

A. **DEFINITION(S):**

1. **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

B. **PURPOSE:**

1. To provide a statement of Tri-City Healthcare District's (TCHD)~~s~~ policies regarding the distribution of the TCHD Compliance Program Code of Conduct and Policies.

C. **DISTRIBUTION TO EMPLOYEES/DIRECTORS:**

1. ~~The~~ TCHD's Compliance Program Code of Conduct and Policies shall be distributed, either electronically or in hard copy..
2. Compliance Policies will be available electronically on the Policy Management database ~~on~~**via** the Intranet.
3. The above shall be distributed to:
   a. Current employees, including officers and manager;~~s.~~
   b. New employees (within 30 days of their start date), which may be part of ~~the~~ TCHD's orientation process **or**~~,~~ as appropriate and;
   c. Members of the Board of Directors.

D. **DISTRIBUTION TO COVERED CONTRACTORS:**

1. ~~The~~ TCHD's Compliance Program Code of Conduct shall be distributed, either electronically or in hard copy, to all:
   a. Current Covered Contractors, and
   b. New Covered Contractors (within 30 days of their start date).

E. **CERTIFICATIONS:**

1. On an annual basis, each employee and Director shall certify ~~in writing~~ that he or she has read, understands, and will comply with ~~the~~ TCHD's Compliance Program Code of Conduct and applicable Policies.
2. Each new employee and Covered Contractor shall certify ~~in writing~~ that he or she has read, understands and will comply with ~~the~~ TCHD's Compliance Program Code of Conduct and

applicable Policies. Such certification must be obtained within 30 days of employment or contract.

F. **DOCUMENTATION:**

1. Copies of all certification executed in accordance with 8750-546 shall be maintained consistent with ~~the~~ TCHD's document retention policies.

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

1. Compliance Certification Form Sample
2. New Employee Orientation Compliance Certification Form Sample

COMPLIANCE CERTIFICATION FORM SAMPLE

"I hereby certify that I have read, understand, and will comply with Tri-City Healthcare District's (TCHD) Compliance Program Code of Conduct and will adhere to TCHD's Policies and Procedures. I understand that my agreement with this certification is a condition of my employment and/or new contract with TCHD. I also acknowledge that my failure to comply with TCHD's Compliance Program Code of Conduct, and TCHD's Policies and Procedures could lead to the imposition of the disciplinary process (if an employee) or appropriate sanction (if not an employee)."

_____ Date:_____
Printed Name

_____ Position:_____
Signature

NEW EMPLOYEE ORIENTATION

COMPLIANCE CERTIFICATION SAMPLE

I hereby certify that I have read, understand, and will comply with Tri-City Healthcare District's (TCHD) Compliance Program Code of Conduct and will adhere to TCHD's Policies and Procedures.

Print Name

Signature Date

I hereby understand that my agreement with this certification is a condition of my employment with TCHD. I also acknowledge that my failure to comply with TCHD's Compliance Program Code of Conduct, and TCHD's Policies and Procedures could lead to me being subjected to the disciplinary process.

Print Name

Signature Date

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Education and Training; ~~General~~ Annual Compliance Training Program; Notices and Updates

REVISION DATE(S):

POLICY NUMBER: 8750-547

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~10/15~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~10/15~~07/20
Organizational Compliance Committee Approval: 09/20
Administration Approval: 10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~: ~~11/15~~ n/a
Board of Directors Approval ~~Date(s)~~: 12/15

A. **PURPOSE:**

1. To provide **information regarding** ~~a statement of~~ Tri-City Healthcare District's (~~"~~TCHD~~"~~) ~~policies regarding~~ **~~of the~~ Compliance** ~~the general annual education and~~ **~~Program~~Training Program's~~s~~** ~~training~~ **policies.** ~~program for all employees, Covered Contractors and Directors ("General Compliance Training Program").~~

B. **DEFINITIONS:**

1. Learning Management System ("LMS"): software application for the administration, documentation, tracking, reporting and delivery of educational courses or training programs.

~~B.~~**2. Workforce Member: Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

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

~~TCHD develops and implements healthcare compliance education and training as part of the TCHD Compliance Program ("Compliance Program").~~

~~TCHD develops and implements additional training as needed for updates and changes to the program.~~

1. TCHD shall provide ~~a General~~ Compliance Training **and education** ~~Program~~ to all ~~employees~~ **Workforce Members** and Members of the Board of Directors **("Board") at least** annually **or as needed when updates or changes may occur.** ~~.~~
2. New ~~employees~~ **Workforce Members~~,~~** ~~and including Ccovered Ccontractors,~~ shall be trained pursuant to the ~~General~~ Compliance Training Program within 30 days of their date of hire or contract.

D. **PROCEDURE:**

~~D.~~1. **PARTICIPATION:**

~~1.~~a. All Members of the Board ~~of Directors, employees, and Covered Contractors~~ **and Workforce Members** shall participate in ~~the~~ TCHD's ~~General~~ Compliance Training Program **as well as additional training for changes and updates that may occur.** ~~.~~ For **Workforce Members who are** employees, such participation shall be a condition of employment.

~~2.~~**b.** Participation shall be documented~~,~~ and~~,~~ for employees~~,~~ will be a critical employee performance evaluation factor.

~~3.~~**c.** Failure to participate will be considered a violation of the Compliance Program and will result in corrective and/or disciplinary action, as appropriate. -The procedures for imposing corrective and/or disciplinary action are set forth in **Administrative Policy** 8750-562 – Responding to Compliance Issues; Remedial Action.

~~4.~~**d.** The Chief Compliance **and Privacy** Officer shall determine**, on a case by case basis,** whether any ~~C~~**c**overed ~~C~~**c**ontractor does not have to participate in the ~~General~~ Compliance Training Program.

~~E.~~**2. DELIVERY:**

~~1.~~**3.** The ~~General~~ Compliance Training– Program may be presented in any manner the Chief Compliance **and Privacy** Officer determines to be effective. This may include, ~~for example,~~ in-person training, video conference training, computerized training **(Netlearning), ~~LMS~~** or telephone conference training.

~~F.~~**4. CONTENT DEVELOPMENT, IMPLEMENTATION AND REVIEW:**

~~1.~~**a.** The Chief Compliance **and Privacy** Officer, with the assistance of the Organizational Compliance Committee and/or ~~legal~~ **General C**ounsel (as necessary), shall be responsible for developing, implementing, regularly reviewing (at least annually), and updating the ~~General~~ Compliance Training Program. The ~~General~~ Compliance Training Program shall cover at least the following topics:~~.~~

~~a.~~**i.** An overview of TCHD's Compliance Program (with a focus on any modifications or additions since the previous ~~General~~ Compliance Training Program).

ii. TCHD's strong and continuing commitment to compliance with all applicable laws and regulations (with a focus on new legal regulatory developments).

~~b.~~**iii. TCHD's strong ~~and~~ commitment to compliance with HIPAA, and ~~state patient information and~~ security laws.**

~~c.~~**iv.** A discussion of the ~~then current~~ Compliance Program, Code of Conduct and **TCHD** Policies, the requirement that they be followed, and the consequences if they are not.

~~d.~~**v.** The importance of asking questions and seeking the guidance of the Chief Compliance **and Privacy** Officer when in doubt about the propriety of a particular practice.

~~e.~~**vi.** The duty to report any suspected misconduct, ~~or~~ practice or activity by a TCHD ~~director, employee, or Covered~~ **covered** ~~Contractor~~ **contractor ~~or~~ Workforce Member** that ~~the employee~~ **they** believes violates or may violate any laws, regulations, or TCHD's Compliance Program, Code of Conduct or **TCHD** Policies.

~~f.~~**vii.** The methods that can be used to communicate reports of any suspected misconduct or practice that the ~~employee~~ **Workforce Member** believes violates or may violate any laws, regulations~~,~~ ~~or~~ Compliance Program, Code of Conduct or **TCHD** Policies.

~~g.~~**viii.** TCHD's policy of striving to protect the identity of ~~employees~~ **Workforce Members** who report a practice that the ~~employee~~ **Workforce Member** believes violates or may violate any laws, regulations, ~~or~~ Compliance Program, Code of Conduct or Policies, as set forth in **Administrative Policy** 8750-559 – Responding to Compliance Issues – Introduction Reports of Suspected Misconduct; Confidentiality.

~~h.~~**ix.** TCHD's policy of non-retaliation ~~and non-retribution~~ with respect to ~~an employee~~ **a Workforce Member** who, in good faith, reports a practice that the ~~employee~~ **Workforce Member** believes violates or may violate any laws, regulations, ~~or~~ Compliance Program, Code of Conduct or Policies (where the ~~employee~~ **Workforce Member** was not involved in the practice at issue), as set forth in **Administrative Policy** 8750-560 – Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation.

b. **Workforce Members who are employees may have additional mandatory training on the following:**
   i. An overview of government and private payer reimbursement.
   ~~j.~~**ii.** General prohibitions on paying or accepting kickbacks, gifts, or other things of value in exchange for referrals.
   ~~k.~~**iii.** The referral and billing prohibitions of the Stark Law.
   ~~l.~~**iv.** The duty to return and report overpayments.
   ~~m.~~**v.** Proper documentation and the integrity of medical records.
   ~~n.~~**vi.** Proper authorization to provide inpatient services.
   ~~o.~~**vii.** Patient rights and education.
   ~~p.~~**viii.** Medicare conditions of participation.
   ix. Deficit Reduction Act of 2005 ~~and/or~~
   ~~q.~~**x.** State **and** Federal False Claims Acts**.**

5. **~~DOCUMENTATION~~COMPLIANCE NOTICES/UPDATES AND DISTRIBUTION:**
   a. **The Compliance notices/updates shall contain, as appropriate, information regarding:**
      i. **TCHD's commitment regarding compliance;**
      ii. **Changes to TCHD's Compliance Program;**
      iii. **Issues identified by the Chief Compliance and Privacy Officer and/or the Organizational Compliance Committee, as relevant to highlight or discuss;**
      iv. **Recent legal developments related to hospitals;**
      v. **Upcoming compliance training and education programs; and**
      vi. **TCHD's compliance resources (e.g., links to Compliance Program Policies and the number for the Confidential Reporting ValuesLine).**
   b. **The Compliance Program notices/updates may take any form deemed appropriate and effective by the Chief Compliance and Privacy Officer. This may include, paper, email, intranet, and/or included within other regular publications.**
   c. **The Compliance Program notices/updates shall be published on an as needed basis.**
   d. **The Compliance Program notices/updates shall be distributed to all TCHD Workforce Members.**

~~G.~~6. **DOCUMENTATION:**
   ~~1.~~a. ~~TCHD shall maintain, consistent with its document~~ **TCHD ~~R~~r**retention policies **will be followed for maintaining proof of education and training for employees and distribution of notices/updates.** ~~the following in the Compliance Program files~~:
      ~~a.~~i. All materials used in connection with the ~~General~~ Compliance Training Program (e.g., handouts, presentation outlines and videotapes); and
      ii. Sign-in sheets, attendance charts, **~~LMS~~Netlearning completions reports** and/or any other documents used to reflect and confirm participation in the ~~General~~ Compliance Training Program.
      iii. **All Compliance notices/updates.**
      ~~b.~~iv. **Archived copies of the Compliance Program notices/updates shall be available to Workforce Members, upon request.**

E. **RELATED DOCUMENTS:**
1. **Administrative Policy 8750-559 - Responding to Compliance Issues – Introduction Reports of Suspected Misconduct; Confidentiality**
2. **Administrative Policy 8750-560 - Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation**
3. **Administrative Policy 8750-562 - Responding to Compliance Issues; Remedial Action**
4. **Administrative Policy 8610-237 – Hospital Records Retention**
5. **Board Policy #19-008 – Records Retention and Destruction**
~~2.~~6. **TCHD Code of Conduct**

~~H.~~**F. REFERENCES:**

~~1. Administrative Policy 8750-559 - Responding to Compliance Issues – Introduction Reports of Suspected Misconduct; Confidentiality~~

~~2. Administrative Policy 8750-560 - Responding to Compliance Issues; Introduction; Reports of Suspected Misconduct; Non-Retaliation~~

~~3. Administrative Policy 8750-562 - Responding to Compliance Issues; Remedial Action.~~

1. Deficit Reduction Act of 2005

2. ~~;~~ State **and** Federal False Claims Act**s**

3. Stark Law

4. Anti-Kickback Statute

~~4.~~**5. State and Federal HIPAA Rules and Regulations**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
COMPLIANCE

ISSUE DATE: 05/2012

SUBJECT: Education and Training; Specific Training Programs

REVISION DATE(S): 01/16

POLICY NUMBER: 8750-548

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~11/15~~06/20	
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:		~~11/15~~07/20
Organizational Compliance Committee Approval:	09/20	
Administration Approval:	10/20	
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	~~01/16~~	n/a
Board of Directors Approval ~~Date(s)~~:	01/16	

A. **PURPOSE:**

1. To provide a statement of Tri-City Healthcare District ("TCHD") policies regarding the provision of specific education and training programs ~~for employees (and certain directors and Covered Contractors, as appropriate) related to the TCHD's Compliance Program~~**("Specific Training Programs")**

B. **DEFINITIONS:**

1. **Learning Management System ("LMS"): Ssoftware application for the administration, documentation, tracking, reporting and delivery of educational courses or training programs.**

~~1.~~**2. Workforce Member: Eemployees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors 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.**

C. **POLICY:**

~~B.~~**1.** Schedule:

~~1.~~**a.** Annually, TCHD shall **develop and implement Specific Training Programs** ~~provide specific compliance education and training programs ("Specific Training Programs")~~ for TCHD **Workforce Members** ~~employees~~ who work in risk areas designated by the Chief Compliance **and Privacy** Officer per Administrative Policy 8750-564 Development and Revision of Code of Conduct and Policies.

~~C.~~**b.** **Workforce Members who are** ~~N~~new hires for whom applicable annual Specific Training Programs will not occur within 30 days of their date of hire, shall receive as-needed compliance education and training pursuant to Administrative Policy 8750-549 Education and Training; As-Needed Education and Training.

~~1.~~**2.** Participation

~~1.~~**a.** All TCHD ~~employees~~ **Workforce Members** who work in designated risk areas are required to participate in applicable Specific Training Programs. Participation shall be documented, and will be a critical ~~employee~~ performance evaluation factor. Failure to participate will result in corrective and/or disciplinary action.

~~2.~~**b.** The Chief Compliance **and Privacy** Officer shall determine whether ~~and, if so, which~~**or not** Covered Contractors must participate in Specific Training Programs.

~~3.~~**c.** The Chief Compliance **and Privacy** Officer shall recommend Specific Training Programs to Members of the **TCHD** Board of Directors.

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

~~D.~~**1.** Delivery:

a. Specific Training Programs may be presented in any manner the Chief Compliance **and Privacy** Officer determines to be effective. This may include, for example, in-person training, video conference training, ~~computerized training~~**LMS training** or telephone conference training.

~~E.~~**2. Content Development, Implementation and Review:**

~~1.~~**a.** The Chief Compliance **and Privacy** Officer, with the assistance of the Organizational Compliance Committee and/or ~~legal~~ **general** counsel (as appropriate), shall be responsible for developing, implementing, regularly reviewing (at least annually) and updating ~~the~~ Specific Training Programs.

b. The Chief Compliance **and Privacy** Officer shall be responsible for selecting the topics to be covered by ~~the~~ Specific Training Programs. At a minimum, each program shall include, with respect to the subject matter area in question, a discussion of (1) applicable Compliance Program Code of Conduct Policies, laws and regulations, and (2) recent legal developments related to **health systems**~~hospitals~~.

~~2.~~**3.** Documentation:

~~2.~~**a.** TCHD shall maintain, consistent with its document retention policies, the following in the Compliance Program files:

~~a.~~**i.** All materials used in connection with the Specific Training Programs (e.g., handouts, presentation outlines and videotapes); and

~~b.~~**ii.** Sign-in sheets, attendance charts, **LMS completions reports** and/or any other appropriate documents used to reflect and confirm employee participation in the Specific Training Programs.

~~F.~~**E. ~~REFERENCES~~RELATED DOCUMENTS**:

1. Administrative Policy 8750-549 - Education and Training; As-Needed Education and Training
2. Administrative Policy 8750-564 - Development and Revision of Code of Conduct and Policies

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MAN~~
COMPLIANCE

DELETE – incorporated into Administrative Compliance Policy: Education and Training; General Annual Compliance Training Program

ISSUE DATE: 05/12

SUBJECT: Education and Training; Compliance Notices/Updates

REVISION DATE(S): 12/12

POLICY NUMBER: 8750-550

Department Approval Date(s):	~~11/15~~06/20
Administrative Policies and Procedures Approval Date(s):	~~11/15~~07/20
Organizational Compliance Committee Approval:	09/20
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval Date(s):	~~01/16~~ n/a
Board of Directors Approval Date(s):	01/16

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

~~1. This policy provides (1) a statement of Tri-City Healthcare District's (TCHD) policies regarding the development and distribution of compliance notices and updates.~~

~~B. **PREPARATION:**~~

~~1. The Chief Compliance Officer shall be responsible for developing and distributing Compliance notices and updates. Members of the Organizational Compliance Committee, as well as any other individuals and departments the Compliance Officer deems appropriate, shall provide assistance.~~**contractors,**

~~C. **CONTENT:**~~

~~1. The Compliance notices/updates shall contain, as appropriate, information regarding:~~

~~a. TCHD's commitment regarding compliance;~~

~~b. Changes to TCHD's Compliance Program;~~

~~c. Issues identified by the Chief Compliance Officer and/or the Organizational Compliance Committee as relevant to highlight or discuss;~~

~~d. Recent legal developments related to hospitals;~~

~~e. Upcoming compliance training and education programs; and~~

~~f. TCHD's compliance resources (e.g., links to the Compliance Program Policies and the number for the Confidential Reporting Line Values Line).~~

~~2. The Compliance notices/updates may contain any other information relating to compliance deemed appropriate by the Chief Compliance Officer.~~

~~D. **FORM:**~~

~~1. The Compliance Program notices/updates may take any form deemed appropriate by the Chief Compliance Officer.~~

~~2. The Compliance Program notices/updates may be included within other regular publications.~~

~~E. **DISTRIBUTION:**~~

~~1. The Compliance Program notices/updates shall be published on an as needed basis.~~

~~2. The Compliance Program notices/updates shall be distributed to all TCHD employees.~~

~~3. The Chief Compliance Officer shall determine whether and, if so, which, Covered Contractors shall receive Compliance Program notices/updates.~~

~~4. TCHD may use any appropriate format and distribution method for the Compliance Program notices/updates (e.g., paper, e-mail, intranet).~~

~~5. Archived copies of the Compliance Program notices/updates shall be available to employees, upon request.~~

~~F. **DOCUMENTATION:**~~

~~1. **TCHD shall maintain copies of all Compliance Program notices/updates consistent with its document retention policies.**~~

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/~~May 31, 20~~12

SUBJECT: ~~Monitoring~~ Compliance-Related ~~/Auditing and Reporting;~~ Exit Interviews

REVISION DATE: 07/16

POLICY NUMBER: 8750-554

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~01/16~~06/20	
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:		~~01/16~~07/20
~~**Medical Executive Committee Approval Date(s):**~~	~~02/16~~	
Organizational Compliance Committee Approval ~~Date(s)~~:	~~05/16~~09/20	
Administration Approval:	10/20	
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	~~07/16~~ n/a	
Board of Directors Approval ~~Date(s)~~:	07/16	

A. **PURPOSE:**

1. To provide a statement of Tri-City Healthcare District's (TCHD~~'s~~) policy with respect to conducting compliance-related exit interviews of departing ~~employees and Covered Contractors~~ **Wworkforce Mmembers** to ensure that ~~the District~~**TCHD**'s practices are consistent with the stated policy.

B. **DEFINITIONS:**

~~1. **Covered Contractor:** is an individual or entity that has a contractual relationship with TCHD (other than employment) including but not limited to:~~

~~a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and physician extenders such as physician assistants and nurse practitioners.~~

~~b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state health care program.~~

~~2.~~1. **Workforce Member: Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **POLICY:**

~~a. Employees~~

~~2.~~**1.** To further TCHD's compliance review and monitoring efforts, the Chief Compliance **and Privacy** Officer (or ~~his or her~~ designee) ~~shall~~ **may** seek information about compliance concerns from departing ~~employees~~**Wworkforce Mmembers**. These questions may be asked as part of an exit interview ~~survey utilized by TCHD's~~ **process performed by the** Human Resources Department. As part of this **process the** ~~optional interview or survey, the~~ departing **Wworkforce Mmember** ~~employee shall~~ **may** be **given an opportunity to convey any observations, suggestions, or complaints regarding TCHD's operations, practices, Compliance Program and/or compliance initiative, generally.** ~~:~~

~~i. Asked whether he or she is aware of any past or ongoing potential or actual violations of laws and regulations, or TCHD's Compliance Program Policies and Procedures or~~

~~Code of Conduct and, if so, to provide detail.~~

~~ii. Required to return to TCHD the originals and any copies of any TCHD documents in the employee's possession.~~

~~iii. Given an opportunity to convey any observations, suggestions, or complaints regarding TCHD's operations, practices, Compliance Program and/or compliance initiatives generally.~~

~~D. COVERED CONTRACTORS:~~

~~1. At his/her discretion, the Chief Compliance Officer (or his or her designee) shall seek information about compliance concerns from Covered Contractors (as defined in Administrative Policy 8750-537 – Hiring and Employment; Definitions) whose contracts with TCHD have expired. As part of this interview or survey, each departing Covered Contractor shall be:~~

~~a. Asked whether he or she is aware of any past or ongoing potential or actual violations of laws and regulations or the TCHD's Compliance Program Policies or Code of Conduct and, if so, to provide detail.~~

~~b. Invited to convey any observations, suggestions, or complaints regarding TCHD's operations, practices, Compliance Program and/or compliance initiatives generally.~~

~~c. Required to return to TCHD the originals and any copies of any TCHD Documents in the Covered Contractor's possession.~~

~~E.~~D. **DOCUMENTATION:**

1. The information obtained during exit interviews shall be considered confidential to the extent allowed by law and documented in ~~the~~ **NavexEthicsPoint.** ~~Compliance Program files consistent with the TCHD's document retention policies.~~ TCHD shall make every effort to obtain signed and dated statements when feasible.
2. TCHD shall document compliance ~~with Policy 8750-554~~ in the departing employee's/Covered Contractor's file consistent with the TCHD's document retention policies.

~~F.~~E. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-537 - ~~,~~ Hiring and Employment; Definitions
2. **Administrative Policy 8610-237 – Hospital Records Retention**
3. **Board Policy #19-008 – Records Retention and Destruction**

~~1.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~Policy Manual~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities

REVISION DATE:

POLICY NUMBER: 8750-556

Administrative Compliance Content Expert Approval: ~~11/15~~06/19
Administrative Policies & Procedure Committee Approval ~~Date(s)~~: ~~11/15~~06/19
Organizational Compliance Committee Approval: 09/20
Medical Executive Committee Approval: n/a
Administration Approval: 10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s):01/16~~ n/a
Board of Directors Approval ~~Date(s)~~: 01/16

A. **PURPOSE:**

1. To set forth the commitment of Tri-City Healthcare District (TCHD) to develop and foster a culture of open communication regarding **TCHD** Compliance Program **("Compliance Program")** matters so that questions are freely asked and suspected misconduct and irregularities are reported.
2. **To provide a confidential reporting process for Workforce Members to report conduct, incidents or practices that may violate TCHD policies or related state and federal laws and regulations.**

B. **DEFINITIONS:**

1. **Workforce Members: 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.**
2. ~~1.~~ **Values Line: TCHD's Confidential Reporting Line that is operated by an independent third party ~~(EthicsPoint by NAVEX Global)~~ and is available 24 hours a day, 365 days a year. See TCHD Values Line Information sheet for contact information. ~~The telephone number is 844-521-7862 and the URL is https://tchd.ethicspoint.com.~~**

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

1. TCHD shall develop and maintain open lines of communication regarding Compliance Program matters in an effort to prevent and detect violations of applicable laws and regulations, the **TCHD** Code of Conduct and the Compliance Program Policies and Procedures. Such communication shall occur without fear of retribution or retaliation. It also can be made on an anonymous basis.
2. ~~1.~~ **Callers may choose to voluntarily identify themselves, or to remain anonymous. Workforce Members are encouraged to identify themselves when reporting, as it often is easier to assess the issues or concerns raised in a report when there is the ability to ask the reporting Workforce Member follow-up questions.**
3. **Workforce Members**~~TCHD employees~~ have a duty to report suspected misconduct or

other activity that the **Workforce Member**~~employee~~ in good faith believes violates or may violate any laws, regulations, TCHD Policies and Procedures or the TCHD Code of Conduct.

4. **Call tracking, tracing, or recording will not be utilized. Additionally, the third-party contractor does not generate or maintain any internal connection logs with IP addresses, so no information linking your PC to the vendor is available. A report from any internet portal will remain secure and anonymous. An internet portal never identifies a visitor by screen name and the contractor's system strips away internet addresses so that anonymity is totally maintained.**

~~2.~~5. **Action will be taken as needed, based on the results of the investigation of the complaint.**

~~C.~~D. **PROCEDURE ~~FOR REPORTING SUSPECTED MISCONDUCT AND FOLLOW-UP ACTIONS~~:**

1. Reporting Required:
   a. TCHD-~~employees~~ **Workforce Members** shall report any suspected misconduct or any other activity, practice or arrangement that the **Workforce Member**~~employee~~ in good faith believes violates or may violate any laws, regulations, TCHD Policies and Procedures or its Code of Conduct.
2. To Whom~~.~~**:**
   a. Reporting of potential compliance irregularities must be made to the **Workforce Member's**~~employee's~~ direct supervisor or the Chief Compliance Officer **(CCO)** or the Values Line.
   b. Reporting of suspected **Workforce Member**~~employee~~ misconduct should be reported to the **Workforce Member's**~~employee's~~ direct supervisor, Human Resources, or the Values Line.

~~D.~~3. Form of Report~~ – Procedure~~**:**
   ~~1.~~**a.** Reports of suspected misconduct or potential irregularity may be made either in writing or orally.
   ~~2.~~**b.** Written reports include reports made via regular mail or email. Such reports should be sent addressed to the Chief Compliance Officer at Tri-City Healthcare District, 4002 Vista Way, Oceanside, CA 92056, or to the **Workforce Member's**~~employee's~~ supervisor.
   ~~3.~~**c.** Oral reports include reports made in-person or via telephone. Oral reports may be made to TCHD's ~~Confidential Reporting Line~~ (Values Line~~) at 1-800-273-8752. The confidential Reporting Line is operated by an independent third party and shall be available 24 hours per day, 7 days per week. Employees do not need to provide their names when making a report, although they are encouraged to do so to facilitate any appropriate or necessary follow up~~. **Workforce Members may make a report anonymously.** An interview specialist will log the **Workforce Member's**~~employees~~ concern and assign a reference number. If the **Workforce Member**~~employee~~ calls back and provides the reference number, he or she will be able to obtain an update on the status of the matter.
   ~~a.~~**d.** Anonymity. Reports, whether written or oral, may be made anonymously. **Workforce Members do not need to provide their names when making a report, although they are encouraged to do so to facilitate any appropriate or necessary follow up**~~However, employees are encouraged to identify themselves when reporting, as itoften is easier to assess the issues or concerns raised in a report when there is the ability to ask the reporting employee follow-up questions~~.
4. Chief Compliance Officer Actions:
   a. The ~~Chief Compliance Officer~~**CCO** shall document follow-up action taken as a result of any written or oral reports.

b. The ~~Chief Compliance Officer~~**CCO** shall keep confidential (to the extent possible)the identity of the person(s) who report suspected misconduct.

c. The ~~Chief Compliance Officer~~ **CCO** shall provide to the Chief Executive Officer (CEO), Audit, Compliance and Ethics Committee and the Board of Directors (BOD), as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.

~~i.~~**d.** The ~~Chief Compliance Officer~~ **CCO** shall make available every report of suspected misconduct to any independent review team charged with conducting annual Compliance Reviews. An Independent review team shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the ~~Compliance Officer~~**CCO** and the CEO.

~~E.~~**5.** Documentation:

~~1.~~**a.** The ~~Chief Compliance Officer~~**CCO** shall maintain, in appropriately designated Compliance Program files, copies of any written reports submitted pursuant to ~~Policy 8750- 556~~**this policy**.

~~2.~~**b.** The ~~Chief Compliance Officer~~ **CCO** shall document any oral reports submitted pursuant to ~~Policy 8750-556~~**this policy** and shall maintain such documentation in the Compliance Program files.

~~3.~~**c.** The ~~Chief Compliance Officer~~**CCO** shall maintain copies of all reports submitted to the ~~Confidential Reporting Line (~~Values Line~~)~~ in the Compliance Program files.

~~4.~~**d.** In conformity with generally accepted compliance review procedures, final copies of work papers, notes and other documentation generated in connection with every written or oral report shall be maintained in the Compliance Program files.

~~5.~~**e.** The ~~Chief Compliance Officer~~**CCO** shall document follow-up action taken as a result of any written or oral reports and shall maintain such documentation in the Compliance Program files.

~~6.~~**f.** The ~~Chief Compliance Officer~~**CCO** shall keep confidential (to the extent possible) the identity of the person(s) who reports suspected misconduct.

~~7.~~**g.** The ~~Chief Compliance Officer~~**CCO** shall provide to the CEO and the BOD, as appropriate, a quarterly summary of any action taken in response to reports that have been verified as compliance or legal violations.

~~8.~~**h.** The ~~Chief Compliance Officer~~**CCO** shall make available every report of suspected misconduct to any independent review team charged with conducting Annual Compliance Reviews. An independent review team shall provide a summary of all reports of suspected misconduct in its findings and conclusions to the ~~Chief Compliance Officer~~**CCO** and the CEO.

~~9.~~**i.** All documentation enumerated above shall be maintained consistent with the TCHD's document retention policies.

~~F. QUESTIONS RELATING TO MONITORING COMPLIANCE:~~

~~1. Any questions about Administrative Policy 8750-556 – Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities and 8750-557 – Communicating and Reporting Compliance Concerns (Values Line) should be directed to the Chief Compliance Officer.~~

~~G. AUDIT AND DOCUMENTATION:~~

~~1. TCHD shall audit and document compliance with Administrative Policies 8750-556 and 8750- 557, pursuant to Administrative Policy 8750-553 – Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits. Relevant documentation shall be maintained in the TCHD's compliance files, consistent with the TCHD's document retention policies.~~

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

~~1. Administrative Policy 8750-553 Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits~~
~~2. Administrative Policy 8750-556 Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities~~
1. ~~Administrative Policy 8750-557 Communicating and Reporting Compliance Concerns (Values Line)~~
2. **Administrative Compliance Policy: Monitoring Compliance/Auditing and Reporting; Annual Compliance Work Plan 8750-552**
3. **Administrative District Operations Policy: Business Visitor Visitation Requirements 8610-203**
4. Board of Directors Policy #14-008 – Records Retention and Destruction
5. **TCHD Values Line Information**

F. **REFERENCE(S):**
1. **Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.**
2. **Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.**
~~4.~~**3. Code of Conduct**

Tri-City Health Care Distri
Oceanside, California

ADMINISTRATIVE ~~POLICY MANU~~
COMPLIANCE

DELETE: Policy combined with Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556

ISSUE DATE: 05/12

SUBJECT: Communication and Reporting Compliance Concerns (Values ~~L~~Line)

REVISION DATE(S): 08/15

POLICY NUMBER: 8750-557

Administrative Compliance Content Expert Approval:	~~10/18~~06/19
Administrative Policies & Procedures Committee Approval:	~~05/15~~06/19
Organizational Compliance Committee Approval:	09/20
Medical Executive Committee Approval:	n/a
Administration Approval:	10/20
Audit, Compliance & Ethics Committee Approval:	~~08/15~~ n/a
Board of Directors Approval:	08/15

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

~~1. This policy:~~

~~a. Ensures availability of a confidential reporting process~~

~~b. Ensures compliance with the U.S. Department of Health & Human Services, Office of Inspector General and Office of Civil Rights ("OCR") Privacy Program Guidance~~

~~2. Establishes guidelines for utilization of the Confidential Reporting Line (Values Line). **The purpose of this policy is to provide a confidential reporting process for Workforce Members to report conduct, incidents or practices that may violate TCHD policies or related state and federal laws and regulations.**~~

~~**DEFINITION:**~~

~~**Workforce Member: employees, 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.**~~

~~B. **SPECIFIC POLICIES AND PROCEDURESPOLICY:**~~

~~1. The Values Line is available 24 hours per day, 365 days per year at 1-800-273-8452**844-521-7862**, or www.tricitymed.alertline.com**https://tchd.ethicspoint.com**.~~

~~2. Callers may choose to voluntarily identify themselves, or to remain anonymous. Employees are encouraged to identify themselves when reporting, as it often is easier to assess the issues or concerns raised in a report when there is the ability to ask the reporting employee follow-up questions.~~

~~3. Calls may be made without fear of retaliation or retribution.~~

~~4. Call tracking, tracing, or recording will not be utilized.~~

~~Action will be taken as needed based on the results of the investigation of the complaint.~~

~~**PROCEDURE:**~~

~~5. A communications specialist answers each call.~~

~~6. The caller may be asked questions by the communications specialist to clarify the concern and ensure accuracy.~~

~~7. The call is assigned a priority rating.~~

~~a. "A" priority: An "A" priority call requires immediate action and notification of the Compliance Officer, Privacy Officer or designee. An "A" priority call involves an~~

~~allegation of threat to person, place, or environment. Follow-up date is one day after the original call.~~

~~b. "B" priority: A "B" priority call is one that requires verbal notification to the Compliance Officer, Privacy Officer or designee during normal business hours or on the next business day if received after normal business hours.~~

~~c. "C" priority: A "C" priority call does not require an immediate response.~~

~~8. The caller is then assigned a control number for follow-up.~~

~~9. The caller is assigned a follow-up date, established according to the priority of the caller's concern. This allows time for an investigation of the concern and provides a method for the **Chief** Compliance Officer **and**or Privacy Officer to communicate (anonymously if necessary) with the caller.~~

~~10. During the follow-up, the caller is provided with an opportunity to report additional information and/or receive a status of their call disposition.~~

~~11. Monthly reports and statistics will be generated by a contracted third party and forwarded to both the **Chief** Compliance Officer and Privacy Officer.~~

~~12. After hours, on holidays and weekends, a contracted third party notifies one of the following of a priority "A" issue:~~

~~a. Chief Nurse Executive~~
~~b. Chief Operating Officer~~
~~c. Chief Compliance Officer **and Privacy Officer**~~
~~d. Privacy Officer~~
~~Senior Director of Risk Management**Clinical Risk Manager**~~

~~**RELATED DOCUMENTS:**~~

~~**Administrative Policy Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits 8750-553**~~

~~**Administrative Policy Communicating and Reporting Compliance Concerns, Reporting of Suspected Misconduct or Potential Irregularities 8750-556**~~

~~13.~~ ~~**Administrative Policy Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556**~~

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
Compliance

DELETE – incorporated into Administrative Compliance Policy: Responding to Compliance Issues – Reports of Suspected Misconduct Investigation 561

ISSUE DATE: 05/12

SUBJECT: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality

REVISION DATE(S):

POLICY NUMBER: 8750-559

Department Approval Date(s):	~~01/16~~06/20
Administrative Policies and Procedures Approval Date(s):	~~01/16~~07/20
~~Medical Executive Committee Approval Date(s):~~	~~02/16~~
Organizational Compliance Committee Approval Date(s):	~~03/16~~09/20
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval Date(s):	~~04/16~~ n/a
Board of Directors Approval Date(s):	04/16

~~A. PURPOSE~~

~~1. To provide a statement of Tri-City Healthcare District's (TCHD's) policy with respect to the confidentiality of reports of suspected misconduct and potential compliance irregularities.~~

~~2. To establish TCHD's commitment to respond promptly and responsibly with respect to compliance issues that are identified by or brought to the attention of TCHD's Chief Compliance Officer.~~

~~DEFINITIONS:~~

~~**Workforce Members: employees, 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.**~~

~~POLICY~~

~~B. RESPONSE TO COMPLIANCE ISSUE REPORT:~~

~~1. When an employee or contractor has made a good faith report of an activity or practice that the employee/contractor believes violates or may violate applicable laws and regulations, TCHD's Compliance Program Policies or its Code of Conduct, the Chief Compliance Officer shall:~~

~~a. Appropriately commend the reporting employee/contractor for making the report and document that commendation in the employee's personnel file.~~

~~b. Strive to keep the identity of the reporting employee/contractor**Workforce Member** confidential until such time as that is no longer possible to avoid impeding an investigation.~~

~~c. Inform the reporting employee/contractor**Workforce Member** (if known) that there may come a point in time where his or her identity may become known or may have to be revealed (e.g., if government authorities become involved in the investigation).~~

~~d. Ensure that no retaliation or retribution action is taken against the reporting employee/contractor**Workforce Member** by virtue of making the report.~~

~~PROCEDURE~~

e. AUDIT/DOCUMENTATION:

2. TCHD shall audit and document compliance issues per Compliance Department processes. Auditing shall be done pursuant to Compliance Department processes.

3. A report shall be made to the Organizational Compliance Committee, as appropriate. Relevant documentation shall be maintained in TCHD's Compliance Program files, consistent with TCHD's document retention policies.

C. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-551 – Monitoring Compliance – Auditing & Reporting; Introduction; General Policies
2. Administrative Policy 8750-552 – Monitoring Compliance – Auditing & Reporting; Annual Compliance Workplan
3. Administrative Policy 8750-553 - Monitoring Compliance – Auditing & Reporting; Compliance Review & Audits
4. Administrative Policy 8750-554 – Monitoring Compliance – Auditing & Reporting; Exit Interviews
5. Policy 8750-560 – Responding to Compliance Issues; Reports of Suspected Misconduct Non-Retaliation
6. Administrative Policy 8750-561 – Responding to Compliance Issues; Reports of Suspected Misconduct; Investigation
7. Administrative Policy 8750-562 – Responding to Compliance Issues; Remedial Action

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 12/12

SUBJECT: Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct

REVISION DATE(S): 12/12, 11/16

POLICY NUMBER: 8750-560

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~01/16~~06/20**
Administrative Policies and Procedures Approval ~~Date(s)~~:	**~~08/16~~07/20**
Organizational Compliance Committee Approval ~~Dates (s)~~:	**~~08/16~~09/20**
~~Medical Executive Committee Approval Date(s):~~	**~~09/16~~**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	**~~10/16~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**11/16**

A. **PURPOSE:**

1. To provide a statement of Tri-City Healthcare District's (TCHD~~'s~~) non-retaliation policy relating to reports of suspected misconduct and potential compliance irregularities. It is ~~the District's~~**TCHD's** intent that no person reporting a compliance concern- be subjected to retaliation in any form. This is consistent with applicable Federal and **S**state laws and regulations, ~~the District's~~ **TCHD's** Compliance Program Policies, and TCHD's Code of Conduct.

B. DEFINITIONS:

1. **Covered Contractor: An individual or entity that has a contractual relationship with TCHD (other than employment).**
2. **Workforce Member: Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

~~B.~~**C. NON-RETALIATION:**

1. When a TCHD ~~employee~~ **Workforce Member** or contractor has made a good faith report of an activity, practice, or arrangement that the ~~employee~~ **Workforce Member** believes violates or may violate applicable laws and regulations, TCHD's Compliance Program Policies, or ~~the~~ TCHD's Code of Conduct:
   a. TCHD **Workforce Members** shall not in any manner harass or engage in retaliation or retribution against the person, whether a **B~~b~~oard of Director (Board)** member, ~~employee~~ **Workforce Member** or contractor for making a report, provided the Board member, ~~employee~~**Workforce Member**/contractor was not involved in the misconduct at issue.
   b. TCHD shall take appropriate corrective and/or disciplinary action against any individual who either commits or condones any act of retaliation, retribution, or harassment against a person who reports a compliance concern. Disciplinary action for ~~employees~~ **Workforce Members** engaging in retaliation can be up to and including termination of employment or affiliation with ~~the District~~**TCHD**.

~~C.~~**D. REPORTING ~~EMPLOYEE'S~~ WORKFORCE MEMBER'S PARTICIPATION IN MISCONDUCT:**

1. TCHD shall take appropriate corrective and/or disciplinary action against any ~~employee~~ **Workforce Member** who violates any laws, regulations, policies and/or TCHD's Code of Conduct, whether or not that ~~employee~~ **Workforce Member** reported such violation.

2. As set forth in Policy 8750-562, the fact that the ~~employee~~ **Workforce Member** reported his or her own misconduct, and the truthfulness and completeness of that self-disclosure, can be a factor in reducing the severity of any corrective and/or disciplinary action.
3. No corrective and/or disciplinary action shall be taken against any ~~individual~~**Workforce Member** who mistakenly but in good faith reported an act reasonably believed to be a compliance violation or other misconduct. ~~Individuals~~ **Workforce Members** may be subject to corrective and/or disciplinary action (if appropriate) if it is determined that a report of wrongdoing or suspected violation of the Compliance Program was not made in good faith (e.g., was knowingly fabricated, distorted, exaggerated or minimized in order to injure someone else, protect himself/herself, or for any other reason).
4. Any ~~individual~~ **Workforce Member** who misuses the Confidential Reporting Line (Values Line) or attempts to interfere with efforts to investigate or address a possible compliance issue is subject to corrective and/or disciplinary action up to and including termination of employment or affiliation with TCHD.

~~D. **DOCUMENTATION:**~~

~~1. TCHD shall document compliance with this policy and maintain such documentation consistent with the document retention policies.~~

E. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-562 – Responding to Compliance Issues; Remedial Action.
2. TCHD Code of Conduct.
3. TCHD Employee Handbook.

F. **REFERENCES:**

1. "False Claims Act" – 31 U.S.C. Sections 3723-3733, a.k.a. "The Lincoln Law"
2. **Department of Health and Human Services Office of Inspector General. Publication of the OIG Compliance Program Guidance for Hospitals (1998)**
3. **Department of Health and Human Services Office of Inspector General Supplemental Compliance Guidance for Hospitals (2005).**
4. **United States Sentencing Commission Guidelines Manual (1 Nov. 2018).**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Responding to Reports of Suspected Non-Compliance and Misconduct; Investigation; Confidentiality

REVISION DATE(S): 01/17

POLICY NUMBER: 8750-561

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~01/16~~06/20**
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:	**~~08/16~~07/20**
Organizational Compliance Committee Approval ~~Date(s)~~:	**~~08/16~~09/20**
~~Medical Executive Committee Approval Date(s):~~	**~~09/16~~**
Administration Approval:	**10/20**
Audit and Compliance Committee Approval ~~Date(s)~~:	**~~01/17~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**01/17**

A. **PURPOSE:**

1. ~~To identify Tri-City Healthcare District (TCHD)'s policy regarding its response to reports of suspected non-compliance and misconduct including the investigation of such reports.~~
2. **To establish Tri-City Healthcare District's (TCHD) commitment to respond promptly and responsibly with respect to compliance issues that are identified by or brought to the attention of TCHD's Chief Compliance and Privacy Officer (CCPO).**
3. **To provide a statement of Tri-City Healthcare District's (TCHD's) policy with respect to the confidentiality of reports of suspected misconduct and potential compliance irregularities.**

B. **DEFINITIONS:**

1. **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **POLICIES:**

1. The ~~Chief Compliance Officer (~~CCPO~~)~~ and/or his or her designee is responsible for conducting and overseeing investigations of reports of potential or actual non-compliance with ethical standards, applicable laws and regulations and TCHD's Code of Conduct and policies and procedures.
2. The CCPO is responsible for reporting the outcome of investigations to Executive Management, Directors and appropriate staff in a timely manner.
3. Reports involving allegations of non-compliance or misconduct by individuals or entities who are hired by the Board **of Directors (Board) (Chief Executive Officer** [CEO]~~, CCO, General Counsel,~~ **and** Board consultants) shall be reported immediately to the Board.
4. **When a Workforce Member ~~or contractor~~ has made a good faith report of an activity or practice that the Workforce Member~~/contractor~~ believes violates or may violate applicable laws and regulations, TCHD's Compliance Program Policies or its Code of Conduct, the CCPO shall:**
   a. **Strive to keep the identity of the reporting Workforce Member confidential until such time as that is no longer possible to avoid impeding an investigation.**
   b. **Inform the reporting Workforce Member (if known) that there may come a point in time where his or her identity may become known or may have to be revealed (e.g., if government authorities become involved in the investigation).**

~~1.~~c. **Ensure that no retaliation or retribution action is taken against the reporting Workforce Member by virtue of making the report.**

~~C.~~D. **PROCEDURES:**

1. Upon receipt of a report of suspected or actual non-compliance or misconduct, a Confidential Reporting Line (Values Line) report, audit findings or other information suggesting a possible compliance issue, the ~~Chief Compliance Officer (~~CCPO~~)~~ will record the information (as detailed below) and develop a preliminary written plan of action, usually within 72 hours of receiving the report unless the reported matter requires immediate attention.
2. If the CCPO makes an initial assessment that the matter **does not** involve a bona fide instance of non-compliance or misconduct and that it warrants no further action, the CCPO will close the report documenting this determination.
3. If the CCPO determines after initial assessment that the matter **does not** involve a bona fide instance of non-compliance or misconduct but raises an area for improvement or concern for future violations, the matter will be referred to the appropriate staff or committee for further action.
4. If the CCPO determines after initial assessment that the matter **does** raise a bona fide concern of suspected non-compliance or misconduct, ~~If~~ the CCPO shall promptly and thoroughly investigate and oversee the investigation of such matter. The CCPO may also, on his/her own initiative, investigate instances of suspected non-compliance or misconduct that have not been reported but are identified through other sources such as audit findings.
5. The scope of the investigation/review will be determined by the ~~Chief Compliance Officer~~**CCPO** or his or her designee~~; however,~~ **and such** investigations/reviews will be conducted in a thorough manner. For example, the veracity of individual statements provided in an interview may be verified by documentary evidence or corroborating evidence.
6. Depending on the nature and severity of the suspected non-compliance or misconduct, the **CCPO** ~~Chief Compliance Officer~~ may consult with appropriate TCHD ~~d~~Departments for additional information.
7. The CCPO may also consult with and utilize outside legal counsel to assist in conducting certain internal investigations or in providing legal guidance and support for CCO investigations.
8. In conducting an internal investigation, the CCPO, his or her designee and other investigators engaged by the CCPO shall as necessary and appropriate:
   a. Take steps to secure, and prevent the destruction of, documents and other evidence relevant to the investigation.
   b. Review relevant documents and data.
   c. Interview persons with relevant information.
   d. Take all reasonable and necessary steps to ensure that identified actual misconduct or non-compliance is stopped and does not recur.
   e. Where the investigation reveals actual coding, billing and/or documentation issues, take all reasonable and necessary steps to ensure that TCHD does not submit non-compliant claims during the pendency of the investigation.
9. Internal investigations may encompass the following components: identification of non-compliant conduct, analysis of the root cause of identified non-compliant conduct, detection of gaps and weaknesses (e.g. function, systems, supervision, education and training, etc.) and recommendations for, and oversight of, corrective and remediation actions.
10. Internal reviews and investigations will be conducted in a fair and objective manner. Individuals involved in the underlying conduct which is the subject of the investigation or review will not direct the investigation.
11. Investigations will be conducted uniformly to the extent possible.
12. The investigation will be conducted and concluded within time periods that are reasonably~~e~~ based on the allegations under investigation and in order to comply with Federal and State fraud and abuse reporting and/or overpayment laws where such matters are at issue.
13. If applicable, the CCPO will review whether any implemented "litigation hold" needs to be released before closing the investigation.

~~D.~~E. **DOCUMENTATION:**

1. Upon conclusion of the investigation a short, written report will be prepared by the ~~Chief Compliance Officer~~**CCPO** or his or her designee or other party approved to conduct the investigation which will generally include:
   a. A description of the allegation(s)
   b. A description of the nature of the suspected matter investigated (if different than the allegation(s))
   c. The investigation procedures
   d. Identification of the persons involved and their role in the conduct ~~(consistent with policy 8750-559; Reports of Suspected Misconduct: Confidentiality)~~
   e. Conclusions related to whether the suspected allegations are unfounded or founded
   f. Description of corrective actions/remediation and
   g. Where applicable, an estimate of the nature and extent of liability or overpayment due.
2. TCHD shall maintain in a confidential and secure fashion, copies of any work papers, interview notes and any other documents generated as part of the internal investigation.
3. TCHD shall maintain in the Compliance Program files copies of any key documents that relate to the practice or matter under investigation.
4. TCHD shall document the scope, findings and recommendations of the internal investigation and shall maintain such documentation in the Compliance Program files.
5. In connection with any internal investigation, TCHD shall maintain in a confidential and secure fashion any documents, whether electronic or hard copy, that are attorney-client communications or attorney work-product. Such documents should be appropriately labeled or stamped as attorney-client privileged or attorney work product and maintained consistent with District's document retention policies. However, failure to label such documents in this manner will not mean the documents are not protected under the attorney-client privilege or attorney work product doctrine.

F. AUDITING:

1. **TCHD shall audit and document compliance issues per Compliance Department processes.**
2. **A report shall be made to the Organizational Compliance Committee, as appropriate. Relevant documentation shall be maintained in TCHD's Compliance Program files, consistent with TCHD's document retention policies.**

~~E.~~G. REPORTING:

1. The CCPO will report the outcome of investigations to Executive Management, the Board ~~of Directors~~ and other ~~staff~~ **Workforce Members** (if and as appropriate) in a timely manner. Reporting mechanisms will vary and will be determined by the CCPO.
2. The CCPO will review whether the investigation results must be reported to any regulator and the mechanism for doing so. The CCPO will confer with Executive Management and the Board as appropriate before submitting such reports.
3. The CCPO will notify the CEO, Board ~~of Directors~~ and General Counsel immediately if any report or subsequent investigation suggests that the conduct at issue raises criminal ramifications.

~~2.~~H.

~~F.~~I. CONFIDENTIALITY:

1. The existence and substance of the investigation or review will be kept confidential to the extent possible and as appropriate under the circumstances and applicable laws and regulations.

~~G.~~J. ~~REFERENCES~~RELATED DOCUMENTS:

~~Administrative Policy 8750-559; Reports of Suspected Misconduct: Confidentiality~~

1. ~~Administrative Policy 8610 – 424; Coaching and Counseling for Work Performance~~**Administrative Compliance Policy: Monitoring Compliance – Auditing & Reporting; Introduction; General Policies 8750-551**
2. **Administrative Compliance Policy: Monitoring Compliance – Auditing & Reporting; Annual Compliance Workplan 8750-552**
3. **Administrative Compliance Policy: Monitoring Compliance – Auditing &**

Reporting; Exit Interviews 8750-554

4. **Administrative Compliance Policy: Non-Retaliation for Responding Compliance Issues or Suspected Misconduct 8750-560**
5. **Administrative Compliance Policy: Responding to Compliance Issues; Remedial Action 8750-562**
~~3.~~6. **Code of Conduct**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Responding to Compliance Issues; Remedial Action

REVISION DATE: 12/12, 03/17

POLICY NUMBER: 8750-562

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~01/17~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~01/17~~07/20
Organizational Compliance Committee ~~Date(s)~~: ~~01/17~~09/20
~~**Medical Executive Committee Approval Date(s):** 02/17~~
Administration Approval: 10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~: ~~03/17~~ n/a
Board of Directors Approval ~~Date(s)~~: 03/17

A. **PURPOSE:**

1. This policy sets forth Tri-City Healthcare District's (TCHD) policy governing remedial actions taken in response to identified misconduct, and procedures to ensure that TCHD's practices are consistent with the stated policy.

B. **DEFINITION(S):**

1. **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

~~B.~~C. **PROGRAMMATIC CORRECTIVE ACTIONS:**

1. TCHD shall take appropriate remedial actions to correct internal operational or programmatic deficiencies identified by the Chief Compliance **and Privacy** Officer **(CCPO)**, Organizational Compliance Committee, Audit, Compliance and Ethics Committee, or Board of Directors in connection with a report prepared per Policy 8750-561.
   a. If the violation involves an ongoing activity or practice,
      i. The activity or practice shall be stopped, and
      ii. The Compliance Department shall be notified of the violation.
      iii. The Compliance Department shall notify outside legal counsel when appropriate.
   b. If the violation involves federal or state health care programs, the **CCPO**~~Chief Compliance Officer~~, in conjunction with ~~regulatory~~ **general** counsel, shall evaluate the violation and determine an appropriate course of action.
   c. If the same or a similar violation could or might be prevented in the future by making changes to TCHD's Compliance Program, such changes shall be considered, developed, instituted, and promptly communicated to all affected employees.

~~C.~~D. **CORRECTIVE AND/OR DISCIPLINARY ACTION:**

1. A~~n~~ **Workforce Member**~~employee~~ who ~~has~~ violate~~sd~~ any laws, regulations, policies, or the Code of Conduct shall be subject to a corrective plan of action and/or disciplined, as appropriate.
2. TCHD ~~also~~ may take corrective and/or disciplinary action against supervisors who fail to detect or report misconduct on the part of **Workforce Members**~~employees~~ under their supervision.
3. Any **Workforce Member**~~employee~~ who intentionally files a false report of misconduct ~~also~~ shall be subject to corrective and/or disciplinary action.

4. Corrective and/or disciplinary action shall take one or more of the following forms:
   a. Imposition of a corrective action plan, which may include training, education and/or other remedial measures
   b. Verbal warning
   c. Written warning
   d. Final written warning
   e. Administrative leave with pay
   f. Suspension without pay
   g. Intent to terminate
   h. Termination
5. When corrective and/or disciplinary action is appropriate, the severity of the disciplinary action will depend on a variety of factors, including:
   a. The nature and severity of the violation
   b. Whether the violation was committed intentionally, recklessly, negligently, or accidentally
   c. Whether the **Workforce Member**~~employee~~ had previously violated any laws, regulations, or policies or the Code of Conduct
   d. Whether the **Workforce Member**~~employee~~ self-reported ~~his or her~~**their**-misconduct
   e. Whether (and the extent to which) the **Workforce Member**-~~employee~~ cooperated with TCHD in connection with its investigation of the misconduct
6. The determination as to the appropriate disciplinary action will be made by members of senior management (in consultation with the **CCPO**~~Chief Compliance Officer~~ and the employee's supervisor, as appropriate).

~~D.~~E. DISCLOSURE; RESTITUTION:

1. If the **CCPO**~~Chief Compliance Officer~~ believes that there has been a material violation of any laws or regulations, outside ~~I~~**L**egal counsel shall be consulted to determine whether ~~District~~ **TCHD** should
   a. Make a report to appropriate government authorities and/or
   b. Make a repayment of any kind to the government or other entity or person (if a program overpayment has been determined), and/or
   c. Perform another type of remedial action

~~E.~~F. CONTINUAL MONITORING AND FOLLOW-UP AUDITS:

1. Any issue for which corrective action is taken (whether or not in the form of a formal corrective action plan), will be targeted for monitoring and review in future audits of that department or area. Investigative findings will be incorporated into department education and training.

~~F.~~G. DOCUMENTATION:

1. TCHD shall document any remedial actions taken pursuant to this policy and maintain such documentation in the Compliance Program files consistent with TCHD's document retention policies. This is in addition to any documentation maintained by the Human Resources Department.

~~G.~~H. RELATED DOCUMENTS:

1. Administrative Policy 8750-561; Responding to Compliance Issues; Reports of Suspected Misconduct; Confidentiality
2. Administrative Policy 8610-424; Coaching and Counseling for Work Performance

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: **Development and Revision of Code of Conduct and Policies; Retiring Standards Contained within the Code of Conduct and/or Compliance Policies**

REVISION DATE(S): 11/16

POLICY NUMBER: 8750-564

Administrative Content Expert~~Department~~ Approval ~~Date~~:	**~~08/16~~06/20**
Administrative Policies and Procedures Committee Approval ~~Date~~:	**~~08/16~~07/20**
Organizational Compliance Committee ~~Date (s)~~:	**~~08/16~~09/20**
~~Medical Executive Committee Approval Date(s):~~	**~~09/16~~**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	**~~10/16~~** n/a
Board of Directors Approval ~~Date(s)~~:	**11/16**

A. **PURPOSE:**

1. To provide a statement of Tri-City Healthcare District's (TCHD~~'s~~) policy regarding the development, review and revision of the Code of Conduct and Policies implementing TCHD's Compliance Program, and helps ensure TCHD's practices are consistent with its stated policies.

~~1.~~**2.** To provide a statement of Tri-City Healthcare District's (TCHD's) policy regarding retiring portions of TCHD's Code of Conduct and/or any Compliance Policies, and ensures TCHD's practices are consistent with its stated policies

B. DEFINITION(S):

1. Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

~~B.~~**C. DEVELOPMENT OF SPECIFIC POLICIES AND PROCEDURES:**

1. The Chief Compliance **and Privacy** Officer **(CCPO)**, in conjunction with the Organizational Compliance Committee (and ~~legal~~ **general** counsel ~~and others~~, as appropriate), shall develop TCHD's Code of Conduct and identify and develop the Policies necessary to ensure the effectiveness of TCHD's Compliance Program for recommendation to the Board of Directors.
2. The Compliance Program Policies shall specifically address the seven factors identified by the **Office of Inspector General** (OIG), as fundamental to an effective compliance program. Specifically, the Policies shall address:
   a. Implementing written standards, policies;
   b. Designating a Chief Compliance Officer and compliance committee;
   c. Conducting effective training and education;
   d. Developing effective lines of communication;
   e. Conducting internal monitoring and auditing;
   f. Enforcing standards through well-publicized disciplinary guidelines; and

g. Responding promptly to detected problems and undertaking corrective action.

3. The Policies shall specifically address "risk" areas identified by OIG, in applicable compliance program guidance or otherwise, as well as risk areas identified by other agencies of the federal government, or which the **CCPO**~~Chief Compliance and Privacy Officer~~ determines are relevant to TCHD.
4. All Policies shall be clear and concise and follow the same general format
5. New Policies, while in development, shall be discussed with the appropriate persons in the affected department(s). If a department proposes a policy, it must provide any supporting documents, for evaluation by the **CCPO**~~Chief Compliance and Privacy Officer~~.

~~C.~~D. REVIEW OF CODE OF CONDUCT AND POLICIES:

1. The **CCPO**~~Chief Compliance and Privacy Officer~~, in conjunction with the Organizational Compliance Committee, shall review the Code of Conduct and all related compliance policies, as necessary, but at a minimum, once every twelve (12) months.
2. The **CCPO**~~Chief Compliance and Privacy Officer~~ shall propose modifications and amendments to the Code of Conduct and/or policies, as appropriate, to reflect:
   ~~i.~~**a.** Changes in applicable laws and regulations, including changes in applicable coverage and reimbursement laws, regulations and decisions.
   b. Changes in the nature or scope of ~~the District's~~ TCHD's business (including TCHD's contractual obligations), and
   ~~i.~~**c.** Indications that existing policies have been ineffective in preventing compliance violations or new or additional policies would be more effective in preventing or avoiding the recurrence of misconduct.
3. Where appropriate, the **CCPO**~~Chief Compliance and Privacy Officer~~, in conjunction with the Organizational Compliance Committee, shall propose revisions to TCHD's Code of Conduct policies.
4. Proposed revisions shall be discussed with appropriate persons in the affected department**(s)** before implementing changes.
5. Any revision must be approved by the Board of Directors.

E. ~~AUDIT AND DOCUMENTATION~~RETIRING STANDARDS CONTAINED WITHIN THE CODE OF CONDUCT:

1. **The CCPO~~Chief Compliance and Privacy Officer~~, a member of the Organizational Compliance Committee and/or another Workforce Member may propose that a Standard contained within the Code of Conduct and/or Policy be retired.**
2. **In order for a Standard contained within the Code of Conduct or Policy is to be retired, the CCPO~~Chief Compliance and Privacy Officer~~ must determine, in consultation with the managers of the relevant/affected department, that the Standard contained within the Code of Conduct or Policy has become obsolete, and document this fact in writing.**
3. **In order for all or a portion of the Code of Conduct to be retired, the Board of Directors must find that the Standard contained within the Code of Conduct at issue has become obsolete or has changed substantially.**
4. **Retired Standards of the Code of Conduct and Policies shall not be destroyed, but shall be removed from current distribution and appropriately archived in accordance with CHA Title 22 Record Retention Regulations.**
5. **All Workforce Members will be notified when a particular Standard contained within the Code of Conduct and/or Policy is retired and, if a new Standard contained within the Code of Conductor Policy is put in its place.**

~~D.~~F. AUDIT AND DOCUMENTATION:

1. TCHD shall document compliance with the Development and Revision of Conduct

Policies (8750-564 and 8750-567). Such audit shall be conducted pursuant to Policy 8750-553. Relevant documentation shall be maintained in TCHD's Compliance Program Files, consistent with its documentation retention policies.

~~E.~~G. **DOCUMENTATION:**

1. The **CCPO**~~Chief Compliance **and Privacy** Officer~~ shall maintain copies in the Compliance Program Files of:
   a. All final versions of the Code of Conduct.
   b. All final versions of compliance policies.

~~F.~~H. **RELATED DOCUMENTS:**

1. Administrative Policy 8750-553 – Monitoring Compliance Auditing and Reporting – Compliance Reviews and Audits.
2. ~~Administrative Policy 8750-567 – Development and Revision of Code of Conduct and Policies; Retiring Code of Conduct and/or Policies.~~

Tri-City Medical Cent
Oceanside, California

DELETE – incorporated into Administrative Compliance Policy: Development and Revision of Code of Conduct and Policies 564

ADMINISTRATIVE POLICY ~~MAN~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Development and Revision of Code of Conduct and Policies; Retiring Code of Conduct and/or Policies

REVISION DATE(S):

POLICY NUMBER: 8750-567

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~01/16~~06/20
Administrative Policies and Procedures Approval ~~Date(s)~~:	~~01/16~~07/20
~~Medical Executive Committee Approval Date(s):~~	~~04/16~~
Organizational Compliance Committee Approval	09/20
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	~~07/16~~ n/a
Board of Directors Approval ~~Date(s)~~:	07/16

~~A. PURPOSE:~~

~~1. To provide a statement of Tri-City Healthcare District's (TCHD's) policy regarding retiring portions of the TCHD's Code of Conduct and/or any Compliance Policies, and ensures TCHD's practices are consistent with its stated policies~~

~~B. RETIRING POLICIES:~~

~~1. The Chief Compliance **and Privacy** Officer, a member of the Organizational Compliance Committee and/or another employee may propose that a Standard of Conduct and/or Policy be retired.~~

~~2. In order for a Standard **Code** of Conduct or Policy and Procedure to be retired, the Chief Compliance **and Privacy** Officer must determine, in consultation with the managers of the relevant/affected department that the Standard**Code** of Conduct or Policy has become obsolete, and document this fact in writing.~~

~~3. In order for all or a portion of the Code of Conduct to be retired, the Board of Directors must find that the Standard**Code** of Conduct at issue has become obsolete **or has changed substantially**.~~

~~4. Retired Code of Conduct and Policies shall not be destroyed, but shall be removed from current distribution and appropriately archived **in accordance with CHA Title 22 Record Retention Regulations**.~~

~~5. All employees will be notified when a particular Standard**Code** of Conduct and/or Policy is retired and, if a new Standard**Code of Conduct** or Policy is put in its place.~~

~~C. RELATED DOCUMENTS:~~

~~1. Administrative Policy 8750-564 – Development and Revision of Code of Conduct and Policies~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Referral Source Policies; Contractual Arrangements with Physicians and Other Referral Sources

REVISION DATE(S): 05/12, 05/16

POLICY NUMBER: 8750-569

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	~~01/16~~06/20	
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:		~~01/16~~07/20
~~**Medical Executive Committee Approval Date(s):**~~	~~02/16~~	
Organizational Compliance Committee Approval ~~Date(s)~~:	~~05/16~~09/20	
Administration Approval:	10/20	
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	~~05/16~~ n/a	
Board of Directors Approval ~~Date(s)~~:	05/16	

A. **PURPOSE:**

1. To provide guidance on requirements for Tri-City Healthcare District's ("TCHD's") contractual arrangements with physicians, physician groups and other referral sources (as defined below) to ensure compliance with applicable Self-Referral and Anti-Kickback Laws.

B. **DEFINITIONS:**

1. Financial Relationship. ~~For purposes of the Referral Source Policies, a "Financial Relationship" means~~ **E**either a compensation arrangement in which remuneration is exchanged between TCHD and a Referral Source (e.g., payment for on call service, rent for use of space) or an ownership or investment interest pursuant to which a Referral Source holds an equity interest in the entity (e.g., shareholder or partner in a joint venture). A compensation arrangement and an ownership/investment interest can be direct or indirect.
2. Immediate Family Member. ~~For purposes of the Referral Source Policies, an "immediate family member" is a~~ **A** spouse or civil union partner; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother or stepsister; father-in law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and the spouse of a grandparent or grandchild.
3. Referral Source. A ~~"Referral Source" means a~~ physician, physician group or any other person or entity that is in a position to refer patients to or otherwise generate revenue for TCHD. ~~For purposes of TCHD's Referral Source Policies (and per certain laws and regulations), the term "~~Referral Source~~"~~ includes the Referral Sources' Immediate Family Members.
4. Remuneration. ~~The term "remuneration" means~~ **A**anything of value, including a salary, stipend or fee, a free or discounted item, forgiveness of debt, e.g., as in a recruitment loan, and the like. For example, when X buys Y a cup of coffee, X has given remuneration (something of value) to Y.
5. Referral Source Policies. Policies that provide guidance to TCHD's staff on how to manage arrangements when the other party is a **R**~~r~~eferral **S**~~s~~ource include but are not limited to:
   a. Administrative Policy Manual #8750-571, Loans & Guarantees to Physicians.
   b. Administrative Policy Manual #8750-572, Medical Directorships.
   c. Administrative Policy Manual #8750-573, Business Courtesies to Physicians and Immediate Family Members.
   ~~d. Administrative Policy Manual #8750-574, Tracking Remuneration and Use of Items and Services to and from Referral Source.~~
   ~~e.~~**d.** Administrative Policy Manual #8750-575, Sale of Items or Services to Physicians and Other Potential Referral Sources.

~~f.~~**e.** Administrative Policy Manual #8750-576, Controls and Monitoring of Payments to Physicians or Other Referral Sources.

~~g.~~**f.** Administrative Policy Manual #8750-580, Physician and Allied Health Professional Service Contracts.

6. Self-Referral and Anti-Kickback Laws. Certain state and federal laws and regulations describing prohibited Financial Relationships with **R**~~r~~eferral **S**~~s~~ources like physicians, physician groups and other **R**~~r~~eferral **S**~~s~~ources and the criteria that must be met to comply with them.

C. **APPLICATION:**

1. Except as set forth immediately below, the Referral Source Policies apply to all Financial Relationships by and between TCHD and a Referral Source.
2. This Policy, however, applies to exchanges of remuneration that occur under or pursuant to one or more contracts. It does not apply to non-contractual exchanges such as medical staff benefits, gifts and other non-monetary compensation. Such other, non-contractual remuneration will be covered by other, more specific Referral Source Policies.
3. Contractual Financial Relationships include, but are not limited to:
   a. Physician recruitment agreements;
   b. Management service agreements;
   c. Professional **s**~~S~~ervices agreements (e.g., on call)
   d. Employment agreements;
   e. Physician expense reimbursement agreements;
   f. Other agreements for the provision of service~~s~~ or supplies (whether medically related or not);
   g. Asset purchase and disposition agreements;
   h. Medical office building, other space, and equipment leases;
   i. Joint ventures; ~~and~~
   j. Certain co-marketing arrangements;~~.~~
   k. Administrative **s**~~S~~ervices **A**~~A~~greements (e.g., Medical Director Agreements);
   l. Physician **c**~~C~~onsultant **a**~~A~~greements; **and**
   m. Medical **s**~~S~~taffing **a**~~A~~greements.
   ~~n. Co-Marketing Agreements~~

D. **PROCEDURES**

1. In General. ~~Various~~ Self-Referral and Anti-Kickback Laws prohibit healthcare providers (such as hospitals) from offering and/or giving remuneration to physicians, physician groups or other Referral Sources for the purpose of inducing patient referrals or otherwise generating business. Some of these laws and regulations also prohibit patient referrals and billing for services furnished to such improperly referred patients when the referring physician has a Financial Relationship with the healthcare provider (e.g., a hospital) and no exception applies. These laws and regulations are complicated and will be addressed in this general policy as well as a number of TCHD's policies related to specific arrangements between and among TCHD and physicians or physician groups (and other Related Sources) such as, by way of example, service arrangements (medical director agreements, on-call agreements, and the like) and lease arrangements. Compliance with the Referral Source Policies is mandatory unless an exception has been granted by the Compliance Department in writing and in advance.
2. Contract Requirements. All of TCHD's contractual arrangements with Referral Sources must:
   a. Be set forth in a current written agreement; one that has not expired or been terminated, which sets forth the parties' respective duties and obligations in sufficient detail and is signed and dated by all of the parties;
   b. Specify the timeframe for, or term of, the arrangement **(at least one year)**;
   c. Specify the remuneration (e.g., rent, purchase price, compensation) to be exchanged, which remuneration must be:
      i. Consistent with fair market value for services or items actually provided;

ii. Determined in a manner that does not take into account the value or volume of referrals or other revenue-generated; and

d. Be intended to obtain or provide an item or service that is reasonable and necessary for a legitimate business purpose.

3. Additional legal requirements: In order to comply with the Stark Law, Anti-Kickback Statute and other laws and regulations, TCHD may have to meet other legal requirements in addition to those set forth above with respect to specific contractual arrangements. (For example, in order to meet the Stark Law exception for Physician Recruitment Agreements, the contractual arrangement must meet ~~specific criteria~~**s Safe Harbor exception**.) Accordingly, TCHD and employees must ensure that other contract/arrangement-specific policies are being reviewed and that they are using appropriate contractual documents or templates that have been reviewed and approved by the Chief Compliance **and Privacy** Officer, ~~Legal~~ **General** Counsel and the TCHD Board **of Directors**.

4. Informal Documents; Amendments; Renewals. Informal documents, such as "letters of intent," "letter agreements," or "memoranda of understanding" are subject to the Referral Source Policies, as are arrangements with physician- owned entities. TCHD must not enter into side agreements or arrangements (written or oral) with physicians. The Referral Source Policies apply to all amendments and extensions/renewals of agreements with physicians ~~as well~~. If at any time it appears that there have been discussions or memoranda indicating intent to obtain or reward referrals by way of an agreement, such agreement shall not be approved.

5. Required Approvals. All contractual arrangements with Referral Sources must be reviewed and approved in advance and in writing by the Chief Executive Officer (or ~~his/her~~ designee), and the Compliance Department and/or ~~Legal~~ **General** Counsel. The review and approvals must be obtained even if the agreement complies in all respects with the Referral Source Policies. The review and approvals also must be obtained for amendments to existing agreements that revise the payment terms and/or the effective dates of the existing agreement. ~~It is not acceptable to obtain the appropriate approvals after making payments in accordance with the agreement.~~ **Payments shall not be made until AFTER all appropriate approvals are in place.** Further, TCHD employees may not make commitments to physicians until written approvals have been obtained.

6. Execution Timing. Both TCHD and the Referral Source must sign and date ~~the relevant~~**all** written agreement(s) before any items or ~~a~~ service**(s)** are provided, and before any payment is made. Any items or services provided before both TCHD and the Referral Source sign the agreement cannot be compensated by TCHD, at the time of service or at any time in the future, unless approved in advance by the Compliance Department

7. Compliance with Contract Terms. In all contractual arrangements with Referral Sources, payments must be consistent with the terms of the agreement and performance of all of the terms of the agreements is required. For example:~~,~~

a. **M**~~m~~onies owed by a physician under a lease agreement must be paid in accordance with the terms of the documents.

b. ~~(Similarly, A~~**a** contractual arrangement that requires time sheets as a condition of payment must be performed and enforced according to its terms. **(** In other words, the obligation to submit complete time sheets cannot be ignored or waived.)

c. Accurate and complete records of all physician receivable collection activity should be maintained by TCHD.

~~7.~~**8.** **Default.** The Compliance Department should be contacted in the event of a default so that remedies may be pursued in a prompt and business-like fashion.

~~8.~~**9.** Contract Database.

a. A centralized and computerized Referral Source Contract Database documenting all contractual relationships with each Referral Source must be maintained. The Referral Source Contract Database should include all current agreements, ~~l~~or financial arrangements between TCHD and any Referral Sources, including Professional Service Agreements, Income Guarantees (Recruitment Agreements), Medical Directorships,

Leases (including those maintained by an independent property manager), Employment Agreements and generally, any Referral Source relationship.

b. ~~The Compliance Department~~**General Counsel** shall be responsible for custody and maintenance of the Referral Source Contract Database and must keep records current and provide timely updates to TCHD's accounts payable management personnel. ~~The Compliance Department~~**General Counsel** must ensure that a copy of each fully executed agreement is maintained in a central repository with copies of all supporting documents, including fair market value verification, Compliance Department approval, and time records.

E. **RELATED DOCUMENTS:**

1. Administrative Policy Manual #8750-571, Loans & Guarantees to Physicians
2. Administrative Policy Manual #8750-572, Medical Directorships
3. Administrative Policy Manual #8750-573, Business Courtesies to Physicians and Immediate Family Members
4. Administrative Policy Manual #8750-574, Tracking Remuneration and Use of Items and Services to and from Referral Source
5. Administrative Policy Manual #8750-575, Sale of Items or Services to Physicians and Other Potential Referral Sources
6. Administrative Policy Manual #8750-576, Controls and Monitoring of Payments to Physicians or Other Referral Sources
7. Administrative Policy Manual #8750-580, Physician and Allied Health Professional Service Contracts

F. **REFERENCES:**

1. 42 U.S.C. Sections 139nn (Physician Self-Referral Law or Stark Law)
2. 42 U.S.C. Section 1320a-7b (Federal Anti-Kickback Law)
3. 42 CFR Sections 411.350 et. seq.
4. 42 CFR Sections 1001.952.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 01/13 **SUBJECT:** Loans and Guarantees to Physicians

REVISION DATE(S): 03/13 **POLICY NUMBER:** 8750-571

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~03/16~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: 07/20
~~**Medical Executive Committee Approval Date(s):**~~
Organizational Compliance Committee: 09/20
Administration Approval: 10/20
Audit ~~and~~, Compliance and Ethics Committee Approval ~~Date(s)~~: n/a
Board of Directors Approval ~~Date(s)~~: 03/13

A. **PURPOSE:**

1. ~~The purpose of this policy is t~~To ensure, through the implementation of prudent and reasonable controls, that Tri-City HealthCare District (TCHD) does not make loans to physicians and does not guarantee loans made to physicians without the prior written approval of legal counsel.

B. **GENERAL POLICIES:**

1. TCHD may not loan money or guarantee the loan of money from a third party lending institution or any other source to a Physician or to any Group Practice without the prior written approval of legal counsel, which can include external or internal **general** counsel. TCHD may pay relocation benefits pursuant to a Relocation Agreement that meets the requirements of this policy and applicable law.

C. **DEFINITIONS:**

1. **Physician - ~~"Physician" means a~~A** duly licensed and authorized doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry or chiropractor or any immediate family member of a physician.

~~1.~~2. **Immediate Family Member: ~~m~~Means** husband or wife; birth or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

3. **Group Practice - ~~"Group Practice" means T~~two** or more Physicians who practice medicine through a single legal entity, using a common trade name and a common tax identification number, including a faculty practice plan or other Physician **G~~g~~roup P~~p~~ractice** organization affiliated with an academic medical center.

~~2.~~4. **Workforce Member~~(s)~~: Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

D. **SCOPE OF POLICY:**

1. This policy applies to:
   a. Tri-City HealthCare District and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");
   b. Any other entity or organization in which Tri-City HealthCare District or an Affiliate owns a direct or indirect equity interest greater than 50%; and

c. Any hospital or healthcare facility in which Tri-City HealthCare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "Tri-City HealthCare District Facility") (collectively, "Tri-City HealthCare District").

E. **PROCEDURES:**

1. **Responsible Parties** – The **Chief** Compliance **and Privacy** Officer**(CCPO)** is responsible for organization-wide compliance with this policy.
2. **Auditing and Monitoring** - The Audit, ~~& Compliance~~ **and Ethics (ACE)** Committee will audit compliance with this policy.
3. **Enforcement** - All ~~employees~~ **Workforce Members** whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject the ~~employee~~ **Workforce Member** to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

F. **REFERENCES:**

1. Tri-City HealthCare District Legal Department Contractual Arrangements Manual
2. Stark Law, 42 U.S.C. § 1395nn, and implementing regulations
3. Definition of Immediate Family Member, 42 C.F.R. § 411.351

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 01/13

SUBJECT: **Business Courtesies to Physicians and Immediate Family Members**

REVISION DATE(S): 09/16

POLICY NUMBER: 8750-573

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~06/16~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~06/16~~07/20
~~**Medical Executive Committee Approval Date(s):** 07/16~~
Organizational Compliance Committee Approval ~~Date(s)~~: ~~08/16~~09/20
Administration Approval: 10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~: ~~09/16~~ n/a
Board of Directors Approval ~~Date(s)~~: 09/16

A. **PURPOSE:**

1. To provide guidance with respect to treatment of compensation in the form of certain items and services under the non-monetary compensation exception and the medical staff incidental benefits exception of the Federal "Stark" law; and to incorporate relevant guidance issued by the Office of Inspector General of the Department of Health and Human Services with respect to certain arrangements that may potentially implicate the Federal "Anti-kickback" statute.

B. **DEFINITIONS:**

1. Physician – ~~means a~~**A** doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry, or a chiropractor.
2. Immediate **F**~~f~~amily **M**~~m~~ember or **M**~~m~~ember of a **P**~~p~~hysician's **I**~~i~~mmediate **F**~~f~~amily – ~~means~~ **H**~~h~~usband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.
~~2.~~3. **Workforce Member - 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.**

C. **GENERAL POLICIES:**

1. Except for *bona fide* employment arrangements, all business courtesies offered to Physicians and/or their **I**~~i~~mmediate **F**~~f~~amily **M**~~m~~embers must meet the guidelines stated in this policy as well as applicable law. Nothing in this policy permits the use of a business courtesy that is intended to induce or reward the referrals of patients or that is intended to induce or reward the purchasing, leasing, ordering, or arranging for any good, facility, service, or item paid for by federal or state health care programs.
2. **This policy applies to:**
   a. **Tri-City Health Care District (TCHD) and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");**
   ~~1.~~b. **Any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%.**

~~D. SCOPE OF POLICY:~~

~~1. This policy applies to~~
~~a. Tri-City Health Care District (TCHD) and its wholly-owned subsidiaries and affiliates (each, an "Affiliate");~~

~~b. Any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and~~

~~E.~~D. PROCEDURES:

1. Applicable Stark Law:
   a. Non-Monetary Compensation Exception:
      i. A "financial relationship" as defined under the Stark Law is not created through the provision of compensation from an entity to a **P**~~p~~hysician or ~~his/her~~**their** **I**~~i~~mmediate **F**~~f~~amily **M**~~m~~ember in the form of items or services (not including cash or cash equivalents) that does not exceed an aggregate in the amount set for the current fiscal year (~~$392~~ **423** in ~~2016~~**2020**, see Reference ~~#56~~), adjusted for inflation on an annual basis, if all the following conditions are satisfied:
         1) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated by the referring **P**~~p~~hysician.
         2) The compensation may not be solicited by the **P**~~p~~hysician or the **P**~~p~~hysician's practice (including employees and staff members).
         3) The compensation arrangement does not violate the Federal anti-kickback statute, section 1128B(b) of the Act, or any Federal or State law or regulation governing billing or claims submission.

      ~~ii. TCHD shall track the annual aggregate nonmonetary compensation provided to physicians or their immediate family members, if any, in accordance with TCHD Administrative Policy 8750-574. DO WE DO THIS???~~

      ~~iii.~~**ii.** Where ~~an entity~~**TCHD** has inadvertently provided nonmonetary compensation to a **P**~~p~~hysician in excess of the limit such compensation is deemed to be within the limit if (i) the value of the excess nonmonetary compensation is no more than 50 percent of the limit; and (ii) the **P**~~p~~hysician returns to the entity the excess nonmonetary compensation (or an amount equal to the value of the excess nonmonetary compensation) by the end of the calendar year in which the excess nonmonetary compensation was received **(or date of discovery)** or within 180 consecutive calendar days following the date the excess nonmonetary compensation was received **(or date of discovery)** by the **P**~~p~~hysician, whichever is earlier.
   b. Medical Staff Incidental Benefits Exception:
      i. A "financial relationship" as defined under the Stark Law is not created through the provision of compensation in the form of items or services (not including cash or cash equivalents) from ~~a hospital~~**TCHD** to a member of its medical staff when the item or service is used on ~~the hospital~~**TCHD**'s campus, if all of the following conditions are met:
         1) The compensation is provided to all members of the medical staff practicing in the same specialty (but not necessarily accepted by every member to whom it is offered) without regard to the volume or value of referrals or other business generated between the parties.
         2) Except with respect to identification of medical staff on ~~a hospital~~**TCHD's** **w**~~W~~eb site or in ~~hospital~~ **TCHD** advertising, the compensation is provided only during periods when the medical staff members are making rounds or are engaged in other services or activities that benefit ~~the hospital~~**TCHD** or its patients.
         3) The compensation is provided by ~~the hospital~~**TCHD** and used by the medical staff members only on ~~the hospital~~**TCHD**'s campus. Compensation, including, but not limited to, ~~i~~**I**nternet access, or cell phones, used away from ~~the campus~~**TCHD** only to access ~~hospital~~ **TCHD patient** medical records or information or to access **P**~~p~~atients or personnel who are on the ~~hospital~~ **TCHD** campus, as well as identification of the

medical staff on ~~a hospital~~**TCHD's w**~~W~~eb site or in ~~hospital~~ **TCHD** advertising~~., will meet the "on campus" requirements of this paragraph.~~

4) The compensation is reasonably related to the provision of, or designed to facilitate directly or indirectly the delivery of, medical services at ~~the hospital~~**TCHD**.

5) The compensation is of low value (~~$~~**$~~33~~36** in ~~2016~~ **2020** and adjusted annually for inflation, see Reference ~~#65~~)**~~IS THIS STILL CORRECT?~~** with respect to each occurrence of the benefit (for example, ~~free~~ cafeteria meals available to a **P**~~p~~hysician while ~~he or she is~~**they are** rounding ~~in the hospital~~**at TCHD** must be of low value).

6) The compensation is not determined in any manner that takes into account the volume or value of referrals or other business generated between the parties.

7) The compensation arrangement does not violate the Federal Anti-kickback provision in section 1128B(b) of the Act, or any Federal or State law or regulation governing billing or claims submission.

c. Examples of Business Courtesies/Compensation:

i. Except as otherwise provided herein, examples of business courtesies that must be included as "compensation" under the Stark Law non-monetary compensation exception ~~and tracked by TCHD~~, include, but are not limited to, the following:

1) Business-related meals not furnished in connection with an executed, *bona fide* personal services arrangement as discussed ~~in Section D.2.b.(5) and Section D.2.b.(6)~~ herein;

2) Sporting events or other similar events such as theater and concerts, including the cost of the tickets and a pro rata allocation of the cost of the meal;

3) Local recreational events, such as fishing, boating, hunting and golfing, including cart fees and meals, but excluding the value of the charitable contribution if the event is a charity event;

4) Continuing Medical Education (CME) seminars held off-campus and all CME seminars held on-campus if the value of the on-campus CME seminar is greater than ~~$33~~ **36** per invited **P**~~p~~hysician per occurrence (adjusted annually for inflation, see Reference ~~#65~~);

5) Flowers or other gifts provided to **P**~~p~~hysicians or their **I**~~i~~mmediate **F**~~f~~amily **M**~~m~~embers when they are hospitalized or to recognize a special event, such as a birthday;

6) Room allowances or other financial benefits provided to **P**~~p~~hysician governing board members at a governing board retreat if the benefit is not offered to all governing board members and if the compensation or benefit is not listed as compensation for the member's services in ~~his or her~~**their** appointment letter;

7) Prizes and awards given on special days, such as "Doctor's Day;"

8) ~~h~~**H**oliday gifts given to governing board members and Chiefs of Staff in recognition of the time and energy expended on behalf of ~~the hospitals~~**TCHD** and communities ~~they~~ **it** serve**s**;

9) ~~Subject to Section D.2.b.(7) below, h~~**H**oliday parties for ~~the hospital~~**TCHD**'s employees and their spouses where all the **P**~~p~~hysicians on the hospital's medical staff are invited **(see iii(7) below)**; and

10) ~~Subject to Section D.2.b.(7) below, h~~**H**oliday parties only for the medical staff and their spouses where all members of the medical staff are invited **(see iii(7) below)**.

ii. In no event ~~can~~ **may** ~~the hospital~~**TCHD** provide a Physician with cash or cash equivalents, such as gift certificates, under any of the above situations.

iii. Examples of business courtesies that meet the medical staff incidental benefits exception, the nonmonetary compensation exception, or that meet another Stark

exception and thus do not need to be tracked include, but are not limited to, the following:

1) ~~Free or discounted m~~**M**eals (such as meals served in the **P**~~p~~hysician's lounge), parking and computer/internet access provided ~~in the hospital~~**at TCHD**, so long as they are provided to all members of the medical staff without regard to the volume or value of referrals;
2) CME seminars held on campus provided the value of the CME seminar is less than $3~~63~~ per invited physician per occurrence, or compliance training held in the local service area where the primary purpose of the seminar is compliance training, regardless of cost;
3) When allowed by California law, governing board retreats where ~~the hospital~~**TCHD** pays for travel, food and lodging for all its governing board members and the benefit is included as compensation in the member's appointment letter. In addition, ~~the hospital~~**TCHD** may pay for leisure activities of its **P**~~p~~hysician governing board members and the **P**~~p~~hysician's spouse provided the benefit is provided to all governing board members and the benefit is included as compensation in the member's appointment letter;
4) Meals served at governing board meetings, whether ~~held on campus or off campus~~**or not held at TCHD**;
5) Meals provided to an existing member of the medical staff and their spouse where the purpose of the meal is to recruit a **P**~~p~~hysician or other provider to the community and the meal is attended by a TCHD representative, the existing **P**~~p~~hysician member and the recruit and is pursuant to an executed agreement furnished by TCHD's **general** counsel;
6) Business related meals where the purpose is to discuss the **P**~~p~~hysician's duties under a services agreement with ~~the hospital~~**TCHD** where (i) the agreement specifically contemplates such business meals, and (ii) the meal is modest as judged by local standards and occurs in a venue conducive to conducting a meeting; and
7) One local medical staff appreciation event per calendar year for the entire medical staff, such as a holiday party. Any gifts or gratuities provided in connection with the medical staff appreciation event are subject to the nonmonetary compensation amount and must be tracked and logged.

d. Other Items:
   i. TCHD's CEO or other administrative personnel, including senior management, are not barred from paying for social events such as meals or golf for **P**~~p~~hysicians and the **P**~~p~~hysician's **I**~~i~~mmediate **F**~~f~~amily **M**~~m~~embers who are personal friends. The CEO or other administrative person may not submit the expenditure for reimbursement from TCHD and may not claim the expenditure as a business expense on their personal tax return. TCHD does not expect or encourage this activity as a way of avoiding the limitations otherwise set forth in this policy, and the administrative team and senior management should avoid the ~~appearance~~ **optics** of impropriety in this type of personal entertainment. TCHD anticipates that such events would be infrequent and reciprocal.
e. Auditing and Monitoring:
   i. The Chief Compliance **and Privacy** Officer will monitor compliance with this policy and will bring an annual report to the Audit, Compliance and Ethics Committee for approval.
f. Enforcement:
   i. All ~~employees~~ **Workforce Members** whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject the ~~employees~~ **Workforce Members** to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such

performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

~~F.~~**E. REFERENCE LIST:**

~~1. TCHD Administrative Policy 8750-574 Tracking Non-Monetary Business Courtesies to Physicians and Immediate Family Members~~

~~2.~~**1.** 42 U.S.C. Section 1320a-7b (Federal Anti-Kickback Law)

~~3.~~**2.** 42 U.S.C. 1320a-7b; 42 C.F.R. 1001.952~~(a) (a)~~

~~4.~~**3.** 42 U.S.C. 1395nn; 42 C.F.R. §§411.350-411.361 (Stark Regulations)

~~5.~~**4.** Office of Inspector General of the Department of Health and Human Services Draft Supplemental Compliance Program Guidance for Hospitals, dated June 8, 2004

~~6.~~**5.** **Consumer Price Index-Urban All Item** (CPI-U) Updates:
~~https://www.cms.gov/medicare/fraud-and-abuse/physicianselfreferral/cpi-u-updates.html#~~
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/CPI-U_Updates

Tri-City Medical Cen
Oceanside, California

DELETE – policy to be deleted and readdressed at a later date per Compliance

ADMINISTRATIVE POLICY MA
COMPLIANCE

ISSUE DATE: 03/13

SUBJECT: Tracking Physician Remuneration and Non-Monetary Compensation

REVISION DATE(S): 03/13, 03/17

POLICY NUMBER: 8750-574

Department Approval Date(s):	~~01/17~~07/20
Administrative Policies and Procedures Approval Date(s):	~~01/17~~07/20
Organizational Compliance Committee Approval Date(s):	~~01/17~~09/20
~~Medical Executive Committee Approval Date(s):~~	~~02/17~~
Administration Approval:	10/20
Audit, Compliance and Ethics Committee Approval Date(s):	~~03/17~~ n/a
Board of Directors Approval Date(s):	03/17

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

~~1. To ensure compliance with the federal Anti-Kickback statute and Stark law and the regulations, directives, and guidance related to those statutes.~~

~~B. **GENERAL POLICIES:**~~

~~1. Each Tri-City Healthcare District (TCHD) department shall track remuneration, items, and services provided to or received from Referral Sources. Every Department is responsible for ensuring that, prior to execution; all Referral Source Arrangements are reviewed and approved through TCHD's Contract Approval system (See Administrative Policy 278). TCHD's Compliance Department has adopted a number of policies specific to particular types of Referral Source Arrangements, and each department is responsible for complying with the applicable policies.~~

~~C. **DEFINITIONS:**~~

~~1. Referral Source - means any individual or entity in a position to make or influence referrals to, or otherwise generate business for TCHD. Examples include physicians, medical device companies, pharmaceutical companies, ambulance companies, emergency services providers, etc.~~

~~2. Federal health care program - means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to: Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, Tricare/VA/ CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corps Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Pre-Existing Condition Insurance Plans (PCIPs) and Section 1011 Requests.~~

~~3. Referral Source Arrangement - means any documented arrangement or transaction that involves, directly or indirectly, the offer or payment of anything of value and is between TCHD and any actual source of referrals from Federally funded health care programs; or an arrangement that is between TCHD and a physician (or physician's immediate family member) who makes a referral to TCHD for designated health services as defined under the Stark law.~~

~~4. Remuneration - means anything of value, including, but not limited to, cash, items or services.~~

~~D. **SCOPE OF POLICY:**~~

~~1. This policy applies to (1) TCHD and its wholly-owned subsidiaries and affiliates (each, an "Affiliate"); (2) any other entity or organization in which TCHD or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tri-~~

~~City Healthcare District or an Affiliate either manages or controls the day-to-day operations of the facility (each, a "TCHD Facility") (collectively, "TCHD").~~

~~E. PROCEDURE:~~

~~1. Department~~

~~a. Step 1 – Tracking Remuneration:~~

~~i. Each TCHD Department shall designate an individual or individuals responsible for tracking all remuneration to and from Referral Sources. Such tracking should occur on a regular periodic basis and should be conducted at least once per calendar year for each Referral Source. This tracking shall ensure that all payments to Referral Sources are made in accordance with an approved written agreement.~~

~~b. Step 2 – Tracking Use of Tri-City Health Care District Resources:~~

~~i. Each department shall develop and maintain a reasonable system of monitoring procedures and other internal controls designed to ensure that any services, leased space, medical supplies, medical devices, equipment, or other items provided to Referral Sources are provided pursuant to a written agreement reviewed and approved in advance in accordance with the applicable policy.~~

~~c. The Department staff person responsible for logging remuneration to a physician, or physician group or other entity involving physicians should record the description of the remuneration, the dollar value and the name of the physician in the Shared Folder. They should also note the department reporting the remuneration and the name and position of the person logging the information. The date the remuneration was provided and the date of the entry in the Shared Folder should also be listed.~~

~~d. No later than the second Friday in December, all departments reporting remuneration should log all remuneration provided to physicians, physician groups or other physician entities during the calendar year in the Shared Folder.~~

~~e. No later than the third Friday in December, the Compliance Department paralegal shall reconcile all remuneration provided to physicians and confirm and reconcile this information with the reporting departments. For any physician exceeding the Remuneration Limit (which could change each year), repayment by the physician, physician group or physician entity shall be made.~~

~~f. Documentation of the Repayment must be noted in the designated folder on the Shared Drive.~~

~~2. All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will subject employee to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.~~

~~F. REFERENCE LIST:~~

~~1. Legal Department Contracting Policies~~
~~2. Stark Law, 42 U.S.C. §1395nn, and implementing regulations~~
~~3. Anti-Kickback Law, 42 U.S.C. §1320a-7b(b), and implementing regulations~~
~~4. 42 C.F.R. § 411.357~~

~~G. RELATED DOCUMENT:~~

~~1. Administrative Policy 8610-278; Contract Review~~
~~2.~~1. ~~Administrative Policy 8750-569; Referral Source Policies ; Contractual Arrangement with Physicians and Other Referral Sources~~

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 11/12

SUBJECT: HIPAA Administrative Requirements

REVISION DATE: 12/13, 06/15

POLICY NUMBER: 8610-585

Administrative Content Expert Approval:	**06/20**
Administrative Policies & Procedures Committee Approval:	**~~05/15~~07/20**
Organizational Compliance Committee Approval:	**09/20**
Administration Approval:	**10/20**
Audit and Compliance Committee Approval:	**~~06/15~~ n/a**
Board of Directors Approval:	**06/15**

A. **PURPOSE:**

1. This policy describes Tri-City Healthcare District's (TCHD) responsibilities related to the administrative requirements of the Health Insurance Portability and Accountability Act (HIPPA) Privacy Rule.

B. **DEFINITIONS:**

1. Business Associate Agreement: an Addendum to an applicable Services Agreement between the District and a Business Associate that outlines the specific obligations of the Business Associate related to the Use or Disclosure of District PHI.
2. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
3. Protected Health Information: individually identifiable health transmitted or maintained in paper or electronic form that is created or received by TCMC AND
   a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
4. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD
5. Workforce **Member**: ~~means e~~Employees, **Medical Staff, Allied Health Professionals (AHP),** volunteers, trainees**, Business Visitors, Covered Contractors** and other persons whose conduct, in the performance of work for TCHD is under the control of TCHD whether or not they are paid by TCHD.

C. **POLICY:**

1. TCHD is a covered entity as defined by the HIPAA Privacy Rule and implementing regulations. TCHD shall comply with HIPAA requirements to:
   a. Designate Privacy and Security Officials
   b. Provide HIPAA-required training
   c. Implement HIPAA policies and procedures
   d. Implement appropriate administrative, technical and physical safeguards to protect PHI
   e. Impose sanctions for failures to comply with TCHD Privacy Policies or requirements of privacy laws
   f. Mitigate harmful effects of a Use or Disclosure in violation of TCHD Privacy Policies and privacy laws

g. Refrain from intimidating or retaliatory acts against individuals for exercising their rights under HIPAA.

2. The designated Privacy and Security Officials will be responsible for the functions required by the HIPAA Security and Privacy Rules and this Policy.

D. **PROCEDURE:**

1. Designation of Privacy Officer and Responsibilities.
   a. TCHD shall designate a Privacy Officer to fulfill the responsibilities of the privacy official under the HIPAA Privacy Rule and this Policy.
   b. The responsibilities of the TCHD Privacy Officer include:
      i. Oversight of ongoing activities related to compliance with TCHD's Privacy Policies and applicable federal and state privacy laws including, without limitation, HIPAA, the California Confidentiality of Medical Information Act (CMIA), and Health and Safety Code Section 1280.15.
      ii. Development and revision of TCHD Privacy Policies and Notice of Privacy Practices (NPP) as necessary to comply with HIPAA and other applicable laws.
      iii. Receipt, investigation and documentation of every complaint which an individual makes regarding TCHD's privacy policies, or Uses or Disclosures of PHI.
      iv. Train and educate Workforce Members on TCHD's privacy policies, HIPAA and other privacy laws.
      v. Oversee retention of HIPAA documentation as required under the Privacy Rule and in accordance with TCHD's Records Retention and Destruction Policy.
      vi. Coordination with Legal, Risk, and other departments as needed to provide a response to individual complaints, identify and mitigate potential violations, respond to breaches, provide further information about matters covered by the NPP, and apply and document appropriate sanctions for failures by Workforce Members to comply with applicable policies and laws.
      vii. Reports to executive management and/or the Board of Directors, as appropriate.
2. Designation of Security Officer and Responsibilities.
   a. TCHD shall designate a Security Officer to fulfill the responsibilities of the security official under the HIPAA Security Rule and this Policy.
   b. The responsibilities of the HIPAA Security Officer include:
      i. Oversight of ongoing activities related to compliance with TCHD's Security Policies and applicable federal and state privacy laws including, without limitation, HIPAA, the California Confidentiality of Medical Information Act (CMIA), and Health and Safety Code Section 1280.15.
      ii. Development and revision of TCHD Security Policies as necessary to comply with HIPAA and other applicable laws.
      iii. Train and education of Workforce Members on TCHD's security policies, HIPAA and other privacy laws.
      iv. Coordination with Legal, Risk, Compliance Officer and other departments as needed to provide a response to individual complaints, identify and mitigate potential violations, respond to breaches and apply and document appropriate sanctions for failures by Workforce Members to comply with applicable policies and laws.
      v. Reports to executive management and/or the Board of Directors, as appropriate.
3. Mandatory Workforce Training
   a. TCHD's Workforce must be trained regarding TCHD's Privacy and Security Policies, and any relevant department procedures necessary to complete their assigned job functions prior to gaining access to PHI, and as soon as possible after joining TCMC, but no later than 60 days thereafter. Education includes on-line education modules. When significant changes occur in the job description of current Workforce Members or to policies and/or procedures, the affected Workforce Members will be retrained or made aware of the changes as soon as possible.

b. Each department is responsible to determine whether other personnel such as individuals under affiliation agreements, staff of a business associate, or a contracted organization that is not a business associate are required to complete TCHD's Privacy training, sign a confidentiality agreement, and/or execute a Business Associate Agreement. Each respective Department is also responsible for ensuring maintenance of these documents (or records) in accordance with TCHD policy.

c. TCHD shall retain documentation demonstrating that each Workforce Member has completed his/her required privacy training as necessary and appropriate to carry out functions within TCHD and the applicable Department.

4. TCHD will undertake appropriate actions to enforce TCHD's Privacy and Security Policies, including applying appropriate disciplinary sanctions against members of its workforce who fail to comply. The type of sanction applied shall vary depending on the severity of the violation, whether the violation was intentional, whether the violation indicates a pattern or practice of improper access, use, or disclosure of PHI, and similar factors. Sanctions taken may include termination.

5. TCHD will implement other HIPAA administrative requirements as set forth in TCHD privacy policies.

E. **REFERENCES:**

1. 45 Code of Federal Regulations (CFR) Section 160.103
2. 45 CFR Section 164.308(a)(2)
3. 45 CFR Section 164.530
4. TCHD Records Retention and Destruction Board Policy # 14-008.
5. Health and Safety Code Section 1280.15

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE:	**12/16**	**SUBJECT:**	**Protected Health Information (PHI) Breach Notification, Response and Reporting**
REVISION DATE(S):		**POLICY NUMBER:**	**8610-586**

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~06/16~~06/20**
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:	**~~07/16~~07/20**
~~Medical Executive Committee Approval Date(s):~~	**~~08/16~~**
Organizational Compliance Committee Approval ~~Date(s)~~:	**~~10/16~~09/20**
Administration Approval:	**10/20**
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~:	**~~11/16~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**12/16**

A. **PURPOSE:**

1. To outline the steps that must be taken by Tri-City Healthcare District (TCHD) to investigate and confirm a Breach and/or unlawful or Unauthorized Access to **Protected Health Information** (PHI) and the requirements for notification of such Breach and/or unlawful or Unauthorized Access to PHI to affected patients and to Federal and/or State regulators.

B. **DEFINITION(S):**

1. **Breach:** **A**~~a~~n impermissible acquisition, access, Use or Disclosure of ~~Protected Health Information~~**PHI** under the Privacy Rule that compromises the security or privacy of the ~~Protected Health Information~~**PHI**.
2. **Business Associate:** **A**~~a~~ person or organization who, on behalf of ~~the District~~**TCHD**, performs certain functions or activities or services that require the Business Associate to create, receive, maintain, or transmit PHI on behalf of ~~the District~~**TCHD** or where ~~the District~~**TCHD** needs to disclose PHI to a Business Associate for the services.
3. **California Department of Public Health (CDPH):** The Department of the State of California to which reports **are made as** required by Health & Safety Code Section 1280.15~~ are made~~.
4. **Disclosure:** **T**~~t~~he release, transfer, provision of, access to or divulging of PHI outside of TCHD.
5. **Electronic Protected Health Information (EPHI):** Individually identifiable health information that is transmitted by electronic media or maintained in electronic media.
6. **Office of Civil Rights (OCR):** The federal entity to which Breach reports **are made as** required under HIPAA~~ are made~~.
7. **Protected Health Information (PHI):** individually identifiable health information transmitted or maintained in paper, ~~ or~~ electronic, ~~ other form~~**at** that is created or received by TCHD ~~AND~~ **and**
   a. Relates to the past, present, or future physical or mental health or condition of an individual; ~~OR~~**or**
   b. Relates to the provision of health care to an individual; ~~OR~~**or**
   c. Relates to the past, present, or future payment; ~~AND~~**and**
   d. Identifies the individual ~~OR~~ **or** with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
8. **Security Incident:** **A**~~a~~ttempted or successful **U**~~u~~nauthorized **A**~~a~~ccess, Use or Disclosure, modification or destruction of information or interference with systems operation**s** in an information system.

~~8.~~**9.** **Tri-City Healthcare District:** **To include, but not limited to, the following entities: Tri-City Medical Center and outpatient clinics, Tri-City Wellness Center outpatient clinics, Tri-City Primary Care and Orthopedic Specialists of North County.**

~~9.~~**10.** **Unauthorized Access:** **A**~~a~~s provided under Health & Safety Code Section 1280.15, the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by the California Confidentiality of Medical Information Act **(CMIA)** or any other statute or regulation governing the lawful access, **U**~~u~~se, or **D**~~d~~isclosure of medical information.

~~10.~~**11.** **Unsecured PHI:** PHI that has not been rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary of the Department of Health and Human Services.

12. **Use:** **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.

~~11.~~**13.** **Workforce Members:** **Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors 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.**

C. **POLICY:**

1. ~~It is the policy of~~ TCHD**'s Chief Compliance and Privacy Officer (CCPO) is responsible for reviewing and** ~~to review and~~ investigat**inge** each report **of suspected, actual** or other discovery of a potential Breach ~~or unlawful~~ or Unauthorized Access to a patient's PHI in order to assess and confirm whether such events have occurred~~and whether notice to patients and reporting to regulators is required.~~. **TCHD's Vice-President of IT is responsible for working with the Chief Compliance and Privacy Officer to investigate suspected Breaches involving EPHI, including those that arise from Security Incidents.**

2. ~~It is the policy of~~ TCHD**'s Chief Compliance and Privacy Officer is responsible for coordinating and** ~~to~~ provid**inge** notice to affected patients of an identified Breach of Unsecured PHI and/or unlawful or Unauthorized Access to PHI and to report such matters to the CDPH, the OCR and/or the ~~Office of the~~ California Office of the Attorney General~~if an~~, as required by law and this Policy.

~~3. TCHD's Privacy Officer is responsible for investigating suspected or actual Breaches and/or any unlawful or Unauthorized Access to PHI and for coordinating notices to patients and reports to regulators. TCHD's Security Officer is responsible for working with the Privacy Officer to investigate suspected Breaches involving EPHI, including those that arise from Security Incidents.~~

D. **PROCEDURE:**

1. Internal Breach Reporting: The following steps must be taken when there is a suspected or ~~known~~ known Breach and/or unlawful or Unauthorized Access of PHI:
   a. Board Members, ~~Employees, interns, physicians~~**Workforce Members**, and Business Associates are required to immediately report a suspected or known Breach and/or unlawful or Unauthorized Access of PHI. Notification can be accomplished through notification to their direct supervisor or to a Director, **Chief Compliance and** Privacy Officer, ~~Security Officer~~**VPhead of Information Technology (IT)**, or via the confidential reporting line (ValuesLine).
   ~~b. Breach Response Team notified of reported Breach and/or unlawful or Unauthorized Access events.~~
   ~~c.~~**b.** **The TCHD Chief Compliance and Privacy Officer will r**~~R~~eview and evaluate~~ion of~~ the Breach report ~~is completed with leadership representatives (i.e. CEO, COO, CFO, CNE, Privacy Officer, HIPAA Security Officer, Director of Regulatory services, etc.) in the areas in which the Breach and/or unlawful or Unauthorized Access occurred~~ to determine ~~the~~:
      i. Date and time of the event(s);
      ~~i.~~**ii.** Included Patient identifiers;
      ~~ii.~~**iii.** Method of the suspected or actual Breach and/or unlawful or Unauthorized Access;

iv. **Identification of the individual(s) (e.g. Workforce Members, business associates) involved in actions that resulted in the suspected or actual Breach or unlawful or Unauthorized Access.**

~~iii. Individual(s) involved in the suspected or actual Breach and/or unlawful or Unauthorized Access;~~

~~iv.~~**v.** Number of patients impacted;

~~v.~~**vi.** Whether the number of patients impacted triggers additional notifications (i.e. fewer than 500 patients involved vs. 500 or greater than patients involved);

~~vi.~~**vii.** Whether the suspected Breach involves Unsecured PHI and/or constitutes unlawful or Unauthorized Access to PHI which must be reported to patients, regulators and/or the media under HIPAA and/or state laws; and

~~vii.~~**viii.** Information that may be used to mitigate potential harm to patients (e.g. return/recovery of PHI, erasure of EPHI from lost or stolen devices, etc.).

~~viii.~~**ix.** Breach activity is reported to the Organizational Compliance Committee and the Audit Compliance and Ethics (ACE) Committee of the Board.

2. Breach Reporting by Business Associates:

a. Business Associates are required to notify **the** TCHD **Chief Compliance and** Privacy Officer of Breaches of Unsecured PHI and/or unlawful or Unauthorized Access to PHI without unreasonable delay and no later than ~~24 hours~~**five (5) business days** from the date of the potential/actual Breach.

~~b. To the extent possible, Business Associates should provide TCHD with the identification of each individual affected and identifiers, the date of the Breach or unlawful or Unauthorized Access, as well as any other available information required to be provided by TCHD in the notification to affected individuals or to regulators.~~

~~c.~~**b. The TCHD Chief Compliance and Privacy Officer will r**~~R~~eview and evaluate~~ion of~~ the Breach report ~~is completed with leadership representatives (i.e. CEO, COO, CFO, CNE, Privacy Officer, HIPAA Security Officer, Director of Regulatory services, etc.) in the areas in which the suspected or actual Breach and/or unlawful or Unauthorized Access occurred~~ to determine:

i. Date and time of the event(s);

~~i.~~**ii.** Included Patient identifiers;

~~ii.~~**iii.** Method of the suspected or actual Breach and/or unlawful or Unauthorized Access;

iv. Identification of the individual(s) (e.g. staff member(s), business associates) involved in actions that resulted in the suspected or actual Breach or unlawful or Unauthorized Access.

~~iii.~~**v.** ~~Individual(s) involved in the suspected or actual Breach and/or unlawful or Unauthorized Access~~;

~~iv.~~**vi.** Whether the suspected or actual Breach involves Unsecured PHI and/or otherwise constitutes unlawful or Unauthorized Access to PHI which must be reported to patients, regulators and/or the media under HIPAA and/or state laws;

~~v.~~**vii.** Number of patients impacted; and

~~vi.~~**viii.** Whether the number of patients impacted triggers additional notifications (i.e. fewer than 500 patients involved vs. 500 or greater than patients involved); and

~~vii.~~**ix.** Information that may be used to mitigate potential harm to patients (e.g. return/recovery of PHI, erasure of EPHI from lost or stolen devices, etc.).

3. Breach Response:

a. Breaches or Unlawful or Unauthorized Access Related to PHI – Privacy:

i. Incident/Breach is reported to ~~the Facility~~**TCHD's Chief Compliance and** Privacy Officer. Details relating to the issue are confirmed in writing by the area/department involved in the suspected or actual Breach or unlawful Unauthorized Access. Information includes:

1) Date/Time of the events.

2) Patient/Patient's involved in the events (unauthorized disclosure).

a) Confirmation of the PHI elements involved.

~~3) Identification of the individual(s) (e.g. staff member(s), business associates) involved in actions that resulted in the suspected or actual Breach or unlawful or Unauthorized Access.~~

3) Interview those persons involved in discovering the suspected Breach or unlawful or Unauthorized Access and others who may have knowledge.

4) Confirmation of steps taken to mitigate the confirmed Breach or unlawful or Unauthorized Access~~, including any identified Security Incident that results in a Breach of Unsecured PHI.~~

~~5) Notification Date/Time of Privacy Officer.~~

b. Breaches or Unlawful or Unauthorized Access Related to EPHI – Security:

i. Security Incident or other suspected or actual Breach, unlawful or Unauthorized Access (including Security Incidents) related to EPHI is reported to TCHD's ~~HIPAA Security Officer~~**VP of IT**. Details relating to the event are evaluated and documented to include:

1) Dates/Times when the event occurred/was discovered
2) Current Date/Time
3) Name of Individual(s) who discovered the Breach or Unlawful or Unauthorized Access
4) To whom was the breach reported;
5) Date/Time Breach Response Team notified
6) Confirm whether and to what extent systems and data exposed, accessed or destroyed, if any
   a) What system(s) is affected
   b) What type of breach occurred
   c) What was stolen
   d) Who all is aware of the breach
7) Secure the premises and information systems locations as appropriate.
8) Determine immediate actions that need to be taken to secure information systems and EPHI (e.g. take the affected server, application, etc. off-line, wipe portable devices, etc.)
9) Interview those persons involved in discovering the suspected Breach or unlawful or Unauthorized Access and others who may have knowledge.
10) Confirm need to engage a forensics team to assist in review.

c. Consult with ~~Legal~~ **General** Counsel, as necessary and appropriate.

4. Breach Notifications

a. Following a Breach of Unsecured PHI, TCHD**'s Chief Compliance and Privacy Officer, or designee,** will provide notification of the Breach of Unsecured PHI or unlawful or Unauthorized Access to PHI to:

i. Affected individual(s) ~~(by the Privacy Officer)~~

1) Notification is provided via first class mail or e-mail (if the patient has requested to receive~~d~~ information in this manner).
2) Notice must be provided within 15 days.

ii. CDPH

1) Upon **determination by the Chief Compliance and Privacy Officer that the** ~~receipt of communication relating to a~~ Breach of Unsecured PHI and/or unlawful or Unauthorized Access to PHI **requires notification to CDPH**, the ~~Director, Regulatory Services~~**Chief Compliance and Privacy Officer, or designee,** will ~~notify~~ **submit a report to** ~~the~~ CDPH via ~~phone call within 5 days with follow-up with written notification submitted~~ **its designated website** within 15 days of knowledge of the breach.

~~2) The Regulatory Director tracks the breach information to the Professional Affairs Committee.~~

~~a) Individual breach reporting posted by March 31st annually.~~

~~b) Breach of Unsecure PHI numbers greater than 500 are reported within 30 days of the breach.~~

~~3) Name of individual(s) involved in the Breach of Unsecure PHI or unlawful or Unauthorized Access to PHI.~~

~~4) Notice must be provided within 15 days.~~

iii. Office of Civil Rights

1) To be notified on an annual basis **by the Chief Compliance and Privacy Officer, or designee,** (submission required by March 1st).

~~b. To the extent possible, Business Associates should provide TCHD with the identification of each individual affected and identifiers included in the Breach, the date of the Breach, as well as any other available information required to be provided by TCHD in the notification to affected individuals or to regulators.~~

5. Additional Requirements for a Breach where 500 or greater than individuals are affected:
   a. ~~Legal~~ **General** Counsel notified of the Breach;
   b. Determine resources to support of required steps e.g. notifications (preparation, review and distribution), mitigation (e.g. credit report monitoring, IT staff, etc.).
   c. **Consult and Coordinate m**~~M~~edia Notice~~/statement generated to~~ (for 90 days).
   d. TCHD will set up a toll-free call center to be available for patients to call with questions.
   e. Secretary, Office of Civil Rights is notified without delay and in no case later than 60 days following the Breach.
   ~~f. Consult and coordinate notice to local media.~~
   ~~g.~~**f.** Determine appropriate notifications to be posted on TCHD Web-site including distribution of the toll-free number.
   ~~h.~~**g.** For Breaches of unencrypted computerized data that includes personal information, determine whether notice must be given to patients and a copy of the data breach notice (without personal information) must be provided to the California Office of the Attorney General pursuant to California Civil Code sections 1798.29 and 1798.82.
6. Notifications to Insurance Carrier:
   a. TCHD's Privacy Officer shall consult with ~~TCHD Finance and/or Risk Management~~**General Counsel** to determine if notice needs to be provided to any insurance carrier providing coverage for privacy, security and/or cybersecurity incidents.
7. HIPAA Breach Exceptions:
   a. The following scenarios constitute exclusions from Breaches under HIPAA:
      i. Unintentional acquisition, access, or Use of PHI by:
         1) A **W**~~w~~orkforce **M**~~m~~ember, or person acting under the authority of TCHD or a TCHD Business Associate, if such acquisition, access, or **U**~~u~~se was made in good faith and within the user's scope of authority and does not result in a further Use or~~f~~ Disclosure that is not permitted under HIPAA.
      ii. Inadvertent Disclosure of PHI:
         1) By persons authorized to access PHI at TCHD; or by a TCHD Business Associate to another person authorized to access PHI at TCHD or TCHD Business Associate; or to an organized healthcare arrangement in which TCHD participates. Information received as a result of such Disclosure cannot be further **u**~~U~~sed or **d**~~D~~isclosed in a manner not permitted by HIPAA.
      iii. A Disclosure of PHI where TCHD or TCHD Business Associate has a good faith belief that the unauthorized person to whom the impermissible Disclosure was made would not reasonably have been able to retain the information.
8. Burden of Proof:
   a. TCHD is required to demonstrate that all required notifications have been provided or that the Use or Disclosure of Unsecured Protected Health Information did not constitute a Breach. A Breach of PHI is presumed unless TCHD or a Business Associate demonstrates there is a low probability that the PHI has been compromised based on a risk assessment of at least the following factors:

i. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
ii. The unauthorized person who used the PHI or to whom the disclosure was made;
iii. Whether the PHI was actually acquired or viewed; and
iv. The extent to which the risk to the PHI has been mitigated.

~~b. Breach of Unsecured PHI/Unlawful or Unauthorized Access:~~

~~i.~~**b.** TCHD shall maintain documentation that all required notifications were made and for the time required in TCHD**'s document retention p**~~P~~olicy.

c. When a determination has been made that a Breach did not occur and notification is not required the following documentation is maintained:
i. Assessment demonstrating a low probability that the PHI has been compromised by the Impermissible Use or Disclosure; and
ii. The applicability of any other exceptions to the definition of Breach.

9. Distribution of Breach Guidance
a. TCHD **W**~~w~~orkforce **M**~~m~~embers are educated on the process for reporting and notification of a suspected or actual Breach or unlawful or **Una**Authorized Access of PHI upon hire and annually.
b. TCHD Business Associates are required to follow the requirements for handling suspected or actual Breaches or unlawful or **Una**Authorized Access of PHI set forth in their Business Associate Agreement.

E. REFERENCE LIST:

1. Administrative Policy 8610-237: Hospital Records Retention

~~E.~~**F. REFERENCE LIST:**

1. California Health & Safety Code §1280.15
2. California Civil Code Sections 1798.29 and 1798.82
~~2.~~**3. California Confidentiality of Medical Information Act (CMIA)**
~~3.~~**4.** 45 Code of Federal Regulations (CFR) §164.402
~~4.~~**5.** 45 CFR §164.404
~~5.~~**6.** 45 CFR §164.406
~~6.~~**7.** 45 CFR §164.408

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 09/15

SUBJECT: Use and Disclosure of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations (TPO)

REVISION DATE(S):

POLICY NUMBER: 8610-592

Administrative Content Expert Approval:	**06/20**	
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:	**~~06/15~~07/20**	
~~Medical Executive Committee Approval Date(s):~~	**~~07/15~~**	
Organizational Compliance Committee Approval:	**09/20**	
Administration Approval:	**10/20**	
Audit and Compliance Committee Approval ~~Date(s)~~:	**~~07/15~~**	n/a
Board of Directors Approval ~~Date(s)~~:	**09/15**	

A. **PURPOSE:**

1. The purpose of this Policy is to provide guidelines for Uses and Disclosures of ~~PHI~~ **Protected Health Information (PHI)** for Treatment, Payment and Health~~c~~ Care Operations (TPO).

B. **DEFINITIONS:**

1. Authorization: ~~the~~ **The** written form that complies with **the Health Insurance Portability and Accountability Act of 1996** (HIPAA) and state law that is obtained from the ~~i~~Individual or his or her ~~p~~Personal ~~r~~Representative in order for **Tri-City Healthcare District** (TCHD) to ~~u~~Use and ~~d~~Disclose PHI.
2. Covered Entity: Includes health-care providers like ~~the District~~**TCHD** that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing).
3. Disclosure: ~~the~~ **The** release, transfer, provision of, access to or divulging of PHI outside TCHD.
4. Health~~c~~ ~~C~~are Operations: ~~are~~ **Are** certain activities of a Covered Entity to the extent that they are related to covered functions and include, but are not limited to, quality improvement, case management and care coordination, accreditation, certification, licensing, credentialing, conducting or arranging for legal, auditing, compliance functions, business and planning development and business management and general administrative activities.
5. Health~~c~~ ~~C~~are Provider: ~~for~~ **For** purposes of HIPAA, is a person or entity that furnishes, bills or is paid for health care (care, services or supplies related to the health of an individual) in the normal course of business.
6. Payment: ~~includes~~ **Includes** activities undertaken by a health-care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.
7. Protected Health Information (PHI): ~~individually~~ **Individually** identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD ~~AND~~**and**
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment; **and**~~, AND~~

d. Identifies the individual ~~OR~~ **or** with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

8. Treatment: ~~the~~ **The** provision, coordination, or management of health care and related services by one or more providers, including coordination or management of health care by a health-care provider with a third party; consultation between health-care providers relating to a patient; or the referral of a patient from ~~health care from~~ one health-care provider to another.

9. Use: ~~the~~ **The** sharing, application, utilization, examination or analysis of PHI within TCHD

C. **POLICIES:**

1. In general, TCHD may not **u**~~U~~se or **d**~~D~~isclose a patient's PHI without the patient's Authorization, unless otherwise permitted to do so by ~~both~~ state ~~and~~ **or** federal laws.

2. ~~Except as provided under~~ **Under** state and/or federal laws, TCHD may **u**~~U~~se or **d**~~D~~isclose a Patient's PHI for Treatment, Payment and Healthcare Operations (TPO) without ~~a~~ patient ~~Authorization~~**authorization**.

~~2.~~**3. TCHD shall make reasonable efforts to limit PHI to the "Minimum Necessary" (as outlined in TCHD's Administrative Policy 8610-594) to accomplish the intended purpose.**

~~3. If state and/or federal laws require a patient Authorization in circumstances involving TPO, then TCHD must comply with such Authorization requirements.~~

~~4. TCHD shall make reasonable efforts to limit PHI to the "Minimum Necessary" to accomplish the intended purpose. when using PHI for TPO except as otherwise permitted under applicable state and/or federal laws.~~

D. **PROCEDURES:**

1. Treatment
   a. TCHD may **u**~~U~~se or **d**~~D~~isclose PHI for its ~~own Treatment~~ **treatment** purposes.
   ~~b. TCHD may Disclose PHI for Treatment activities of another health care provider.~~
   ~~c.~~**b.** Examples of Treatment include:
      i. Direct and indirect provision of health-care services.
      ii. Coordination and management of health care and related services.
      iii. Consultation with another health-care provider.
      ~~iv.~~ Referrals to other health-care providers such a home health care, physical therapy, and durable medical equipment, etc.

2. Payment
   a. TCHD may **u**~~U~~se or **d**~~D~~isclose PHI for ~~its own Payment~~ **payment** purposes. **Such as:**
      ~~TCHD may Use a patient's PHI to:~~
      ~~i.~~ Determine ~~his or her~~ eligibility for coverage and health-care benefits. ~~under a health care plan.~~
      ~~ii.~~**i.** Submit claims **for payment.** ~~to health plans and other payers for health care services it provides to patients.~~
      ~~iii. Review health care services for medical necessity.~~
      ~~iv. Conduct utilization review activities.~~
   b. TCHD may **d**~~D~~isclose PHI to another Covered Entity or health-care provider for Payment activities of **a covered entity, such as:** ~~the entity~~ **entit**~~that receives the information. For example, TCHD may Disclose PHI to~~
      i. A~~a~~n ambulance supplier
      ii. ~~or h~~**H**ealth-care provider ~~as necessary for that Covered Entity or health care provider~~ to bill and obtain reimbursement for ~~its~~ services.

3. Healthcare Operations
   ~~a. TCHD may Use or Disclose PHI for its own Health Care Operations.~~
   ~~b.~~**a.** ~~Examples of~~ Health~~c~~ Care Operations include **but are not limited to**:
      i. ~~Conduct~~ **Q**quality improvement activities,
      ii. ~~P~~patient safety activities,
      iii. ~~protocol~~ **Protocol** development,
      iv. ~~case~~ **Case** management

v. ~~and~~ **C**~~c~~are coordination ~~and contact providers and patients with information on treatment alternatives and related functions that do not include treatment.~~

vi. **Determine medical necessity.**

~~i.~~**vii. Utilization review**

viii. ~~Review the competence or qualifications of health care~~ **Peer Review**

~~ii. professionals and provider performance, conduct training programs for health care and non-health care professionals and accreditation, certification, licensing or credentialing activities.~~

ix. ~~Conduct or arrange for medical review, L~~legal services, **and**

x. **Auditing functions.**

~~iii. auditing~~ **Auditing** ~~functions, fraud and abuse detection and compliance.~~

~~iv. Undertake business planning and development activities.~~

~~v. Engage in business management and general administrative activities.~~

~~c.~~**b. TCHD may** ~~TCHD may d~~**D**isclose PHI to another Covered Entity ~~for the Health Care Operations of that Covered Entity if: (1) both~~ TCHD and the other Covered Entity has or had a relationship with ~~the patient who is the~~ **the** subject of the PHI being requested; ~~(2) the PHI pertains to such Disclosure; and (3) the Disclosure is for a purpose listed in 3.b.(i) or (ii) above or for the purpose of fraud and abuse detection or compliance.~~

~~4. Patient Authorizations Required for Certain Purposes~~

4. ~~In certain circumstances, the Use and Disclosure of PHI for Treatment, Payment and Health Care Operations is not permitted without a patient's Authorization. State and/or federal laws~~ **State and/or federal laws** may impose stricter standards that require TCHD to obtain ~~Authorizations~~ **authorizations** and/or impose other limitations on the Use and Disclosure of PHI in **certain** ~~these~~ circumstances:

a. ~~Psychotherapy~~ **Mental Health** ~~notes/~~ **Ssubstance Aabuse**: **State and Federal Law** ~~HIPAA~~ HIPAA has special provisions regarding the Use and Disclosure of psychotherapy notes. ~~which must be complied with for all patients in California.~~ Psychotherapy notes require separate ~~Authorizations~~ **authorizations.** ~~under HIPAA – a general request for release of medical records will not suffice~~ (45 Code of Federal Register (CFR) Section 164.508 (a)(2).)

b. HIV test results: California strictly limits the **d**~~D~~isclosure of HIV test results. ~~Generally, with some exceptions~~, California law requires a specific authorization ~~– a general authorization to release medical records is not sufficient.~~ (California Health & Safety Code Section 120980).

c. Marketing: ~~A~~**G**~~Generally, a~~ patient authorization will be required. ~~(45 CFR Section 164[KL1].508(a)(3) and Civil Code Section 56.10(d).)~~ **See also TCHD Administrative Policy: Use and Disclosure of Protected Information for Fundraising 8610-525.**

~~d. Sale of PHI: Generally, a patient authorization will be required. (45 CFR Section 164.508(a)(4) and California Civil Code Section 56.10(d).)~~

~~e. Mental health and substance abuse: State and/or federal laws may impose more protections on the Use and Disclosure of TPO for mental health and substance (alcohol and drug) abuse patients. TCHD employees shall review and follow requirements in applicable TCHD policies and procedures and applicable laws and regulations related to the Use and Disclosure of PHI for Treatment, Payment and Health Care Operations when such services are involved. (45 CFR Section 164.508(a)(2); 42 CFR Part 2; Cal. Welf. & Inst. Code 5328 et seq.)~~

E. REFERENCE LIST:

1. **Administrative Policy 8610-523: Use and Disclosure of Information Regarding Media**
2. **Administrative Policy 8610-525: Use and Disclosure of Protected Information for Fundraising**
3. **Administrative Policy 8610-594: Minimum Necessary Requirements for Use and Disclosure of PHI**

F. REFERENCES:

~~5. 45 CFR Section 160.103~~
~~6. 45 CFR Section 164.501~~
~~7. 45 CFR Section 164.502(b)~~
~~8. 45 CFR Section 164.506~~
1. 45 CFR Section 164.508(a)(2)~~(3) and (4)~~
~~9.~~**2. California Health and Safety Code Section 120980**
~~10. California Civil Code Section 56.10(d)~~
~~11.~~**3.** ~~California Health & Safety Code Section 120980~~**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 12/16

SUBJECT: Minimum Necessary Requirements for Use and Disclosure of PHI

REVISION DATE(S):

POLICY NUMBER: 8610-594

Administrative Content Expert~~Department~~ Approval ~~Date(s)~~: ~~07/16~~06/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~07/16~~07/20
~~**Medical Executive Committee Approval Date(s):** 08/16~~
Organizational Compliance Committee Approval ~~Date(s)~~: ~~10/16~~09/20
Administration Approval: 10/20
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~: ~~11/16~~ n/a
Board of Directors Approval ~~Date(s)~~: 12/16

A. **PURPOSE:**

1. To establish guidelines for compliance with the Health Insurance Portability and Accountability Act (HIPAA) minimum necessary requirements in order to prevent unlawful or unauthorized access to, and Use and Disclosure of, Protected Health Information **(PHI)**~~.~~

B. **DEFINITION(S):**

1. **Authorization:** ~~the~~ **The** written form that complies with HIPAA and state law that is obtained from the individual or his or her Personal Representative in order for Tri-City Healthcare District (TCHD) to **u**~~U~~se and **d**~~D~~isclose ~~Protected Health Information~~**PHI**.
2. **Business Associate:** ~~a~~ **A** person or organization who, on behalf of ~~Tri-City Healthcare District (~~TCHD~~)~~, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of ~~the~~ TCHD or where TCHD needs to **d**~~D~~isclose PHI to Business Associates for the services.
3. **Covered Entity:** ~~includes~~ **Includes** health-care providers like ~~the District~~**TCHD** that transmit health information in electronic form in connection with certain standard transactions (e.g. claims processing).
4. **Disclosure:** ~~the~~ **The** release, transfer, provision of, access to or divulging of PHI outside of TCHD.
5. **Electronic Protected Health Information (EPHI):** PHI that is transmitted by **e**~~E~~lectronic **m**~~M~~edia or **m**~~M~~aintained in **e**~~E~~lectronic **m**~~M~~edia.
6. **Individual:** ~~the~~ **The** person who is the subject of protected health information.
7. **Minimum Necessary:** ~~refers~~ **Refers** to TCHD or a business associate taking reasonable efforts to **u**~~U~~se, ~~Disclosed~~**disclose**, and ~~Request~~ **request** only the minimum amount of ~~protected health information~~**PHI** needed to accomplish the purpose.
8. **Protected Health Information (PHI):** ~~individually~~ **Individually** identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD ~~AND~~**and**
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment;~~,~~ **and**~~AND~~
   d. Identifies the individual **or**~~OR~~ with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
9. **Use:** ~~the~~ **The** sharing, application, utilization, examination or analysis of PHI within TCHD.

10. **Workforce Member**: ~~employees~~ **Employees, Medical Staff, ~~and~~ Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.** ~~Employees, 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.~~

C. **POLICY**:

~~1. Unless an exception applies, Uses and Disclosures of PHI, and requests to other Covered Entities for PHI, shall be limited to the amount of information reasonably necessary to accomplish the purpose of the Use, Disclosure or Request~~**request.**

~~2. TCHD shall identify levels of access, review, or viewing of patient medical information by Workforce members in order to comply with state and federal privacy laws.~~

~~3.~~**1.** TCHD may not **u~~U~~se, d~~D~~isclose or ~~Request~~ request** an entire medical record unless the entire medical record is specifically justified as the amount that is reasonably necessary to accomplish the purpose of the Use, Disclosure or ~~Request~~**request**.

~~4.~~**2.** The minimum necessary requirements do not apply in the following circumstances:

a. Disclosures made or requests by a health-care provider for treatment purposes;
b. Disclosures to the patient who is the subject of the information;
c. Uses or Disclosures made pursuant to an Individual's **a~~A~~uthorization/consent**;
d. Disclosures to ~~the Department of Health and Human Services~~ **local, state and/or federal agencies** when **d~~D~~isclosure** is required ~~under HIPAA~~;
e. Uses or Disclosures required by law; and
f. Uses or Disclosures required for compliance with HIPAA.

D. **PROCEDURE**:

1. Uses: Identification of Workforce **M~~m~~ember** Use of PHI for **J~~j~~ob D~~d~~uties.**
   a. TCHD shall identify persons or classes of persons within TCHD's Workforce **Members** who need access to PHI to carry out their job duties, the PHI or types of PHI needed and conditions of such access.
   b. Each TCHD **d~~D~~epartment** is responsible for making reasonable efforts to limit access to PHI to that necessary to carry out the job duties, functions and/or responsibilities. Role based access relates to both hard copy and electronic medium. ~~[Attachment A identifies the PHI access standards for TCHD Workforce members.]~~
   c. Employee access to their own medical record requires submission of a written request/consent ~~submitted~~ to the Medical Records/Health Information department where a copy or CD of the information requested will be provided.
   d. Questions regarding the minimum necessary requirements should be directed to the Department Supervisor **or** ~~,~~ **Chief Compliance and** Privacy Officer ~~or HIPAA Security Officer~~.
2. Disclosures: TCHD's Disclosures of PHI in **R~~r~~esponse to R~~r~~equests from O~~o~~ther P~~p~~arties.**
   a. For any Disclosure of PHI made on a routine or recurring basis, TCHD must limit the PHI **d~~D~~isclosed** to the amount reasonably necessary to achieve the purpose of the Disclosure. Individual review of each routine or recurring Disclosure is not required. ~~[Attachment B establishes procedures designed to limit the PHI Disclosed by TCHD to the amount reasonably necessary to achieve the purpose of the Disclosure.]~~
   b. For all non-routine/non-recurring Disclosures, TCHD must review the Disclosure on an individual basis ~~in accordance with the criteria set forth in Attachment B.~~.
   c. In certain circumstances, TCHD may (but is not required to) reasonably rely on the judgment of the party who is requesting Disclosure in determining the amount of information that is needed. Reliance is permitted when it is reasonable under the particular circumstances and when the request for Disclosure is made by:
      i. A public official or agency that states that the information requested is the minimum necessary for a permitted purpose under HIPAA (e.g. public health purposes);

ii. Another Covered Entity;
iii. A professional who is a TCHD Workforce ~~M~~member or Business Associate who represents that the information requested from TCHD is the minimum necessary and who makes the request in order to provide professional services to TCHD; and
iv. A researcher with documentation from an Institutional Review Board that complies with 45 CFR Section 164.512(i).

3. Requests: TCHD's ~~R~~requests to ~~O~~other ~~P~~parties for PHI.
   a. For any request of PHI made to another Covered Entity, TCHD must limit such request to the PHI which is reasonably necessary to accomplish the purpose for which the PHI is requested.
   b. For any request of PHI made on a routine or recurring basis, TCHD must limit the PHI to that which is reasonably necessary to accomplish the purpose for which the PHI was requested. Individual review of each routine or recurring request for PHI is not required. ~~[Attachment C identifies procedures designed to limit the PHI requested by TCHD to the amount reasonably necessary to achieve the purpose of the request.]~~
   c. For all non-routine/non-recurring requests for PHI, TCHD must review the Disclosure on an individual basis ~~in accordance with the criteria set forth in Attachment C~~..

~~4. Minimum Necessary Requirements Not Applicable:~~
   ~~a. The minimum necessary requirements do not apply to the following Uses and Disclosures of PHI and/or request for PHI:~~
      ~~i. Disclosures made or request by a health care provider for treatment purposes;~~
      ~~ii. Disclosures to the patient who is the subject of the information;~~
      ~~iii. Uses or Disclosures made pursuant to an Individual's Authorization;~~
      ~~iv. Disclosures to the Department of Health and Human Services when Disclosure is required under HIPAA;~~
      ~~v. Uses or Disclosures required by law; and~~
      ~~vi. Uses or Disclosures required for compliance with HIPAA.~~

E. **RELATED DOCUMENT(S):**
~~1. Attachment A - PHI Access Rights for TCHD Workforce Members~~
~~2. Attachment B – TCHD Disclosures of PHI~~
~~3.~~**1.** ~~Attachment C – TCHD Requests for PHI to Third Parties~~**Administrative Policy 8610-602: Network Access**

F. **REFERENCES:**
1. 45 CFR Section 160.103
2. 45 CFR Section 164.502(b)
3. 45 CFR Section 164.512(i)
4. 45 CFR Section 164.514(d)
5. California Civil Code 56 et seq.
6. California Health & Safety Code Section 1280.15
~~6.~~**7. Health Insurance Portability and Accountability Act of 1996**

ATTACHMENT A
PHI ACCESS RIGHTS FOR TCHD WORKFORCE MEMBERS

Job Title/Category	Description of Permitted PHI Access	Conditions
Attending Physician	All System Components	Provider-Patient Relationship /Need-to- know
Admitting/Registration	Limited to patient demographics, eligibility, and administrative documents	Need-to-know
Business Development	Evaluation of business programs and required quarterly metrics	Need-to-know
Clinical Research	As specified in patient authorization, IRB documentation or data use agreement consistent with 45 CFR 164.512(i)	Research patient only
Coding and Abstracting	Access HIM utilized when coding/abstracting encounters for billing and/or data collection.	Need-to-know
Compliance office	Audits, reviews or investigations	As CCO determines necessary for audits, reviews or investigations.
Cardiology Services	Results of cardiac related tests and procedures performed Powerchart – Nursing module Registration module Laboratory module Diagnostic Imaging module	Need-to-know
Environmental Services	Limited – bed turnover	Need-to-know
Facilities Department	NONE	Not applicable
Finance	Limited - Coded information (DRGs, APR-DRGs, etc.)	To support analysis of patient activity, facility programs and complete accounts payable
Home Health	Home Care/Home Base application in addition to Powerchart discharge information	Patient Care relationship – Need to know
Imaging / Radiology	Powerchart – Nursing module Registration/Scheduling module Laboratory module Diagnostic Imaging module RadNet, PACs system images and results, Powerchart, FirstNet	Need-to-know
Laboratory	Powerchart – Nursing module Registration/Scheduling module Laboratory module – PathNet Diagnostic Imaging module RadNet, PACs system images and results, Powerchart, FirstNet	Need-to-know
Leadership	Powerchart for review of quality measures as well as audits to confirm documentation practices are compliant with regulations.	Minimum necessary to meet the intent of the audit/chart review.
Marketing	As specified in patient authorization	Written consent required by patient/patient rep.
Materials	Limited – as needed to manage ordering, recalls and purchasing	Need-to-know, Recall Follow-up
Medical Records/HIM	Release of Information to Clinics, MD Offices, and external care providers.	Minimum necessary to meet needs or request

	Respond to Quality reviews and RAC related requests.	
Nutrition Services	Powerchart – Nursing module Laboratory module Diagnostic Imaging module FirstNet, SurgiNet	Patient Care Relationship Need-to-know
Privacy Officer	Privacy Officer Audits and Investigations	To support review of appropriate access, use and disclosure by user.
Patient Accounting	All billing and collection activities to include Denials Management, credit balances	Specific documentation to support the appeal of a denial.
Patient Accounts Rep	Registration module Patient Accounts module Coding and Abstracting module	Need-to-know
Patient Care Services	Powerchart – Nursing module Registration module Laboratory module Diagnostic Imaging module FirstNet, SurgiNet	Patient Care Relationship Need-to-Know
Pharmacist	PharmNet and PowerChart Laboratory module	Need-to-know
Pharmacy Technician	Powerchart – Nursing module Laboratory module	Need-to-know
Physical Therapist	Powerchart – Nursing module Registration module Laboratory module Diagnostic Imaging module	Patient Care relationship Need-to-know
Risk, Regulatory Services and Quality	Powerchart for review of quality measures as well as audits to confirm documentation practices are compliant with regulations.	Minimum necessary to meet the intent of the audit/chart review.
Respiratory Therapist	Powerchart – Nursing module Registration module Laboratory module Diagnostic Imaging module	Patient Care relationship Need-to-know
Surgical Services	Surgi-Net system for documentation of details relating to surgical procedures Powerchart – Nursing module Registration module Laboratory module Diagnostic Imaging module	Patient Care relationship Need-to-know
Utilization Management	Entire patient record for treatment and operations. Use of record to support appeals relating to denied days/stays.	Patient Care relationship. Need-to-know.

* Not a comprehensive list

ATTACHMENT B
TCHD DISCLOSURES OF PHI

1. TCHD will be responsible for reviewing requests for Disclosure of PHI to determine whether the minimum necessary requirements apply and, if they apply, to determine what amount of information is appropriate for Disclosure.
2. Once TCHD makes a determination on a particular request, if the type of request becomes routine or recurring, TCHD does not have to review all subsequent requests on an individual basis. This assumes, however, that appropriate steps are taken to limit the Disclosures to the minimum necessary to accomplish the purpose as provided in these guidelines.
3. If the request **IS** made for the purpose of Treatment of a patient by another health care provider, the minimum necessary requirements **do not apply**, and the PHI that is requested may be released.
4. If the request **IS NOT** made for the purposes of Treatment of a patient **BUT** an exception to the minimum necessary requirements applies, TCHD may release the PHI provided that TCHD has authority to disclose the requested PHI under state and federal privacy laws.
5. If the request **IS NOT** made for purposes of Treatment **AND** the minimum necessary standards do apply, then TCHD must:
   a. Confirm that Disclosure of the PHI requested is permitted under applicable federal and state privacy laws.
   b. If the Disclosure of PHI is otherwise permitted under applicable federal and state privacy laws, review the request for the purpose and release only the minimum amount of information necessary to meet the purpose of the request.
   c. If the request does not indicate a purpose, determine whether it is possible to obtain a revised request or a verbal statement of the purpose which should be documented. Once the third party furnishes a description of the purpose, take appropriate action to provide the minimum amount of information necessary to meet the purpose of the request.
   d. The Privacy Officer should be consulted if there are any questions regarding a request for PHI including those circumstances where TCHD intends to rely on the judgment of the party making the request for PHI that the amount of PHI requested is the minimum necessary for the purpose for which it was requested.
   e. The Privacy Officer may also consult with the Chief Compliance Officer and/or legal counsel as necessary and appropriate to respond to Disclosure requests.
6. For Routine or Recurring Disclosures of PHI, TCHD shall Disclose as follows:

Recipient	Purpose	Minimum Necessary
Ambulance Company	Obtain demographic and insurance information for billing	Facesheet or data transfer with patient demographics and insurance information
Attorney	Evaluate individual's medical condition in support of a lawsuit	Specific information request
Collection Agency	Obtain payment on past due accounts	File of patient names, addresses, dates of service and amount owed
Contracted Payor	Validation of services and DRG assignment	Specific medical data under review
Law Enforcement (Police)	Investigation	Review/Evaluate written request to confirm minimum necessary provided to meet elements of the request.
Physician	Administrative oversight ((i.e. Medical Director, Institute operations)	Summary patient information for monitoring program

~~Iron Mountain~~	~~Record retention~~	~~All records to be stored~~
~~Quality Improvement Organizations~~	~~Healthcare operations~~	~~Specific medical data under review~~
~~Recovery Audit Contractor~~	~~Minimum necessary to meet needs or request~~	~~Specific medical data under review~~
~~Shredding Service~~	~~Record Disposal/Destruction~~	~~All records as described in the Services Agreement and BAA~~

~~7. For non-routine Disclosures of PHI, TCHD must review them on a case-by-case basis in accordance with the criteria set forth above.~~

~~a. Patient Request for Continuing Care~~
~~b. Legal Review (internal)~~
~~c. Subpoena~~

~~ATTACHMENT C~~
~~TCHD REQUESTS FOR PHI TO THIRD PARTIES~~

1. ~~TCHD will be responsible for reviewing requests for Disclosure of PHI made to other Covered Entities to determine whether the minimum necessary requirements apply and, if they apply, to determine what amount of information is appropriate for Disclosure.~~
2. ~~Once TCHD makes a determination on a particular request, if the type of request becomes routine or recurring, TCHD does not have to review all subsequent requests on an individual basis. This assumes, however, that appropriate steps are taken to limit the requests to the minimum necessary to accomplish the purpose as provided in these guidelines.~~
3. ~~If the request for PHI IS MADE for the purpose of Treatment of a patient, the minimum necessary requirements do not apply.~~
4. ~~If the request IS NOT made for purposes of Treatment AND the minimum necessary standards do apply, then TCHD must:~~
    a. ~~Request only the minimum necessary to accomplish the purpose for which the request is made.~~
    b. ~~Provide the purpose of the PHI when requesting PHI from other Covered Entities.~~
    c. ~~The Privacy Officer should be consulted if there are any questions regarding a request for PHI including where TCHD intends to rely on the judgment of the party making the request for PHI that the amount of PHI requested is the minimum necessary for the purpose for which it was requested.~~
    d. ~~The Privacy Officer may also consult with the Chief Compliance Officer and/or legal counsel as necessary and appropriate to respond to Disclosure requests.~~
5. ~~For Routine or Recurring requests for PHI, TCHD shall request PHI as follows:~~

~~Request~~	~~Purpose~~	~~Minimum Necessary~~
~~Example:~~ ~~Physician~~	~~Healthcare operations: Quality review~~	~~Specific medical data under review~~
~~Healthcare Facilities~~	~~Healthcare operations~~	~~PHI to provide continuing care~~

6. ~~For non-routine requests for PHI, TCHD must review them on a case-by-case basis in accordance with the criteria set forth above.~~

Community Healthcare & Alliance Committee (No meeting held in October, 2020)

Finance, Operations & Planning Committee (No meeting held in October, 2020)

Audit, Compliance & Ethics Committee (No meeting held in October, 2020)

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

September 24, 2020 – 3:30 o'clock p.m.
Meeting Held via Teleconference

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:30 p.m. on September 24, 2020.

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

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
Scott Livingstone, Chief Operations Officer
Candice Parras, Chief, Patient Care Services
Dr. Gene Ma, Chief Medical Officer
Susan Bond, General Counsel
Anna Aguilar, Vice President/Human Resources
Dr. Mark Yamanaka, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 3:35 p.m. via teleconference with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Nygaard to approve the agenda as presented. Director Chavez seconded the motion. The motion passed unanimously (7-0) via roll call vote.

3. Pledge of Allegiance

   Director Schallock led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the September 24, 2020 Regular Board of Directors Meeting Agenda.

The following individuals requested the right to speak under Item 10, Comments from Members of the Public:

- Kathy Cronce, RN/Chair, Clinical Practice Counsel
- Edmundo Garcia, CNA Labor Representative

5. July, 2020 Financial Statement Results – Mr. Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $49,036
- Operating Expense - $53,221
- EBITDA – $162 EROE – ($2,412)

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

- Net Operating Revenue – $24,693
- Operating Expense - $26,689
- EBITDA – $353
- EROE – ($923)

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

- Average Daily Census – 140
- Adjusted Patient Days – 7,824
- Surgery Cases – 449
- ED Visits – 3,725

- Net Patient Accounts Receivable - $35.3
- Days in Net A/R - 51

There were no questions or comments by Board members.

Mr. Rivas reported based on the past couple of years, September would typically be the month in which the Financial Statement Audit would be presented for acceptance by the Board however this year the audit is delayed as a result of COVID 19 and our receipt of the CARES Act Grant. The Auditors have advised that they are still waiting on audit guidelines from the Government related to the CARES Act grant. Mr. Rivas stated we anticipate bringing the Audit to the Board by the end of October.

6. New Business - None

7. Old Business – None

8. Chief of Staff

a) Consideration of September 2020 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on September 21, 2020.

Dr. Yamanaka, Chief of Staff presented the September 2020 Credentialing Actions for the Board's consideration which included four initial appointments and 24 Reappointments. Dr. Yamanaka reported there are no outstanding issues or additional comments at this time.

There were no questions or comments by Board members.

It was moved by Director Chavez to approve the September 2020 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on September 21, 2020. Director Schallock seconded the motion.

The vote on the motion via a roll call vote was as follows:

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

9. Consideration of Consent Calendar

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

The vote on the motion via a roll call vote was as follows:

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

10. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

11. Comments by Members of the Public

Chairperson Grass recognized Cathy Cronce, RN, Chair of the Clinical Practice Counsel who stated she was speaking on behalf of the nurses. She commented on the need to invest in retaining our valued and beloved employees.

Chairperson Grass recognized Mr. Edmund Garcia, Labor Rep with CNA. Mr. Garcia reiterated comments made by Ms. Cronce. He also commented that the nurses need the Board's support during this pandemic and into the fall.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO provided a brief report, reviewing the following:

- COVID statistics at Tri-City Medical Center
- COVID testing and platforms
- 16-bed inpatient stand-alone psychiatric health facility update and projected timeline
- Crisis Stabilization Units in Oceanside and Vista
- Quality Outcomes
- Finances
- Staffing Update

Mr. Dietlin expressed his appreciation to the nurses, physicians and all ancillary healthcare workers for their continued support during this pandemic.

13. Board Communications

Directors Coulter, Reno and Younger had no comments.

Director Chavez thanked today's speakers for their comments. He commented on Tri-City's low COVID mortality rate which is attributed to the hard work of all of our professionals, especially the nurses. Director Chavez also commented that he is pleased to see Tri-City is meeting the challenges of available PPE.

Lastly, Director Chavez encouraged everyone to get their flu shots by the end of September or early October. Be safe, stay socially distanced and spend more time outdoors.

Director Nygaard reiterated how important it is to keep masked, stay home as much as possible, wash hands frequently and stay six feet apart.

Director Nygaard commented that she is happy to hear we are moving forward on the mental health project and she looks forward to a cooperative relationship with the county.

Director Schallock expressed his appreciation to Mr. Dietlin for his update related to Quality and Behavioral Health. He commented on the fact that our Leap Frog numbers continue to improve.

In closing Director Schallock expressed his appreciation to the nurses, physicians and ancillary healthcare workers for their hard work and diligence during the COVID pandemic.

Lastly, Director Schallock urged everyone to get a flu shot and take appropriate precautions to stay healthy.

14. Report from Chairperson

Chairperson Grass reported October is Breast Cancer Awareness. She commented that the survival rates increase every year due to better treatments such as the intraoperative radiation therapy which is offered by Tri-City Medical Center and earlier diagnosis.

15. Move to adjourn

It was moved by Director Coulter and seconded by Director Reno to adjourn the meeting. The motion passed unanimously (7-0) by a roll call vote.

16. There being no further business Chairperson Grass adjourned the meeting at 4:00 p.m.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

received
10-20-2020

California Special Districts Association
Districts Stronger Together

California Special Districts Association
11121 Street, Suite 200
Sacramento, CA 95814
Phone: 877.924.2732 Fax: 916.520.2470
www.csda.net

2021 CSDA MEMBERSHIP RENEWAL

To:

Tri-City Healthcare District
4002 Vista Way
Oceanside, CA 92056

Membership ID: 1590

Issue Date October 1, 2020

Due Date: December 31, 2020

RM-Regular Member	**$7,805.00**
Optional Purchases	
$25 2021 Required State & Federal Labor Law Poster	$
New Member Benefit! Participants receive CSDA Administrative Salary and Benefits Survey results FREE!	NOW FREE FOR CSDA MEMBERS!
$225 CSDA Sample Policy Handbook	$
Total	$
PAYMENT	
Account Name:	Account Number:
Expiration Date	Auth Signature

Please return this form with payment to CSDA Member Services, 1112 I Street, Suite 200, Sacramento, CA 95814, fax: 916.520.2470. To pay by ACH, please contact membership@csda.net.

OBRA 1993 prohibits taxpayers from deducting, for federal income tax purposes, the portion of membership dues that are allocable to the lobbying activities of trade organizations. The nondeductible portion of your dues is estimated to be 8%. To view dues categories, please visit the CSDA transparency page at www.csda.net

Thank you for being a CSDA Member!

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending Sep 30, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	47,421.57	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	Approx 10,218	$2.58	(a)	35,388.70	07/01/17	06/30/22	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	19,810.00	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
CreekView Orhopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	16,592.85	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,011.00	04/01/20	03/31/21	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	Approx 7,347	$1.35	(a)	10,707.03	07/01/16	06/30/21	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	37,908.00	10/01/12	10/01/22	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	13,356.32	08/08/19	05/31/21	**Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,755.00	02/01/20	09/30/20	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**$ 191,950.47**				

(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 September 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS/ONCC CHEMOTHERAPY RENEWAL	91420 EDU	80.00	83170	BRITTANY LESHEA BUTLER
7632	AMERICAN COLLEGE OF RADIOLOGY	A-237970	825.00	7391	NAZITA SANDERS
7894	ONS/ONCC CHEMOTHERAPY RENEWAL	090220 EDU	458.00	83767	DAGMARA KOLASA

**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.