TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
March 25, 2021 – 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: 853 6111 0103; Passcode: 612974

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	February 2021 Financial Statement Results	10 min.	CFO
6	New Business a) Consideration to nominate Board member as a candidate for the San Diego Local Agency Formation Commission as an alternate Special District member with a term expiring in 2023. b) Consideration to approve Resolution 801, A Resolution of the Tri-City Healthcare District Board of Directors Concurring in the Nomination of Jo MacKenzie To The CSDA Board of Directors	5 min. 5 min.	Chair Chair
7	Old Business – None	--	--
8	Chief of Staff	5 min.	COS

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
	a) March 2021 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on March 22, 2021.		
9	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Consideration to approve an agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity (ROP) testing for a term of 12 months, beginning April 1, 2021 and ending March 31, 2022 for a cost of $3,400 per month, for a total cost for the term of $40,800. (2) Consideration to approve an agreement with TriMedx Holdings, LLC for clinical engineering equipment maintenance for a term of 36 months, beginning May 1, 2021 through April 30, 2024, for an annual cost of $1,465,080, and a total cost for the term of $4,395,240. (3) Administrative & Board Committees **A) Patient Care Services Policies & Procedures** a) Hand Off Communication Policy b) Referrals to Social Services for Patients Identified to be of High Risk Policy c) Release of Deceased Procedure d) Substance Abuse, Patient Policy e) Universal Protocol Procedure **B) Unit Specific – Home Care** a) Hazardous Infectious Materials Management **C) Unit Specific - Medical Staff** a) Peer Review Process: OPPE and FPPE 8710-509 **D) Unit Specific - Surgical Services** a) Admission Discharge Criteria Policy b) Scope of Service of PACU Policy (DELETE) (4) **Community Healthcare Alliance Committee** *(No meeting held in March, 2021)* (5) **Finance, Operations & Planning Committee** *(No meeting held in March, 2021)* (6) **Audit & Compliance Committee** *(No meeting held in March, 2021)* (7) Minutes – Approval of: a) February 25, 2021, Regular Meeting (8) Meetings and Conferences – None (9) Dues and Memberships - None	10 min.	Standard CHAC Comm. FO&P Comm. Audit & Comp. Comm. Standard

	Agenda Item	Time Allotted	Requestor
	(10) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (February, 2021) (d) Reimbursement Disclosure Report – (February, 2021) (e) Seminar/Conference Reports – None		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	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
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

San Diego County
Local Agency Formation Commission
Regional Service Planning | Subdivision of the State of California

RECEIVED
2-2-21

CALL FOR NOMINATIONS

February 22, 2021

TO: Independent Special Districts in San Diego County

FROM: Tamaron Luckett, Commission Clerk

SUBJECT: **Call for Nominations | Alternate Special District Member Election on LAFCO**

This notice serves as a call for nominations pursuant to Government Code Section 56332(1) involving a vacant and unexpired term as alternate special district member on the San Diego County Local Agency Formation Commission (LAFCO). The term involves Erin Lump's (Rincon del Diablo Municipal Water District) vacated seat and expires on May 1, 2023. Additional details follow.

- **Eligibility**
  Candidates eligible for election must be members of the legislative body of an independent special district who reside within San Diego County but may not be members of the legislative body of a city or county.

- **Authorized Nominations**
  State Law specifies only the presiding officer or their alternate as designated by the governing board must sign the nomination form. Attached is nomination form for the LAFCO alternate special district member **(Attachment A)**.

- **Submittal Process and Deadline**
  Signed nominations and a limited **two-page** resume indicating the candidate's District and LAFCO experience must be returned to San Diego LAFCO **no later** than **Friday, April 23, 2021.** Nominations received after this date will be invalid. Nominations and resumes may be mailed to the San Diego LAFCO Office at 9335 Hazard Way, Suite 200, San Diego, CA 92123 or by email to tamaron.luckett@sdcounty.ca.gov, if necessary, to meet the submission deadline, but the original form must be submitted.

Administration
Keene Simonds, Executive Officer
County Operations Center
9335 Hazard Way, Suite 200
San Diego, California 92123
T 858.614.7755 F 858.614.7766
www.sdlafco.org

Vice Chair Jim Desmond, County of San Diego
Nora Vargas, County of San Diego
Joel Anderson, Alt., County of San Diego
Mary Casillas Salas, City of Chula Vista
Bill Wells, City of El Cajon
Paul McNamara, Alt, City of Escondido
Chris Cate, City of San Diego
Marni von Wilpert, Alt, City of San Diego
Jo MacKenzie, Vista Irrigation
Barry Willis, Alpine Fire Protection
Vacant, Alt., Special District
Chair Andy Vanderlaan, General Public
Harry Mathis, Alt, General Public

After nominations and resumes are received it is anticipated a candidate's forum will be held in conjunction with the California Special Districts Association quarterly meeting with confirmation being provided under separate/future cover. Election materials will be mailed out **no later** than **Friday, April 30, 2021** unless otherwise communicated by the LAFCO Executive Officer. Should you have any questions, please contact me at 858.614.7755.

Attachment:
1) Nomination form – LAFCO alternate special district member

Respectfully,

Tamaron Luckett
Commission Clerk

ATTACHMENT A

NOMINATION OF THE SPECIAL DISTRICT REPRESENTATIVE FOR THE SAN DIEGO LOCAL AGENCY FORMATION COMMISSION ALTERNATE MEMBER

The _____ is pleased to nominate _____ as a
(Name of Independent Special District) (Name of Candidate)

Candidate for the San Diego Local Agency Formation Commission as an alternate special district member with a term expiring in 2023.

As presiding officer or his/her delegated alternate as provided by the governing board, I hereby certify that:

- The nominee is a member of a legislative body of an independent special district whom resides in San Diego County.

_____
(Presiding Officer Signature)

_____
(Print name)

_____
(Print Title)

_____
(Date)

PLEASE ATTACH RESUME FOR NOMINEE

- Limit two-pages
- Must be submitted with Nomination Form

RESOLUTION NO. 801

A RESOLUTION OF THE BOARD OF DIRECTORS
OF THE TRI-CITY HEALTHCARE DISTRICT
CONCURRING IN THE NOMINATION OF JO MACKENZIE
TO THE CSDA BOARD OF DIRECTORS

WHEREAS, the California Special Districts Association (CSDA) is holding an election for its Board of Directors for the Southern Network, Seat A for the 2021-23 term; and

WHEREAS, the Tri-City Healthcare District is a voting member of CSDA and a voting member of the Southern Network; and

WHEREAS, the incumbent, Jo MacKenzie, of the Vista Irrigation District is seeking re-election for this position; and

WHEREAS, Jo MacKenzie has been involved with the CSDA Board since 2003 and has served in a wide variety of roles including Board President in 2011, Vice President in 2010, and Treasurer in 2008 and 2009; and

WHEREAS, the Board of Directors of the Tri-City Healthcare District believe that Jo MacKenzie is an effective leader on the CSDA Board.

NOW, THEREFORE, BE IT RESOLVED, that the Board of Directors of the Tri-City Healthcare District does concur in the nomination of Jo MacKenzie to represent the Southern Network, Seat A, on the CSDA Board of Directors; and

BE IT FURTHER RESOLVED that the District Secretary is hereby directed to transmit a copy of this resolution to the attention of the Board Secretary of the Vista Irrigation District at 1391 Engineer Street, Vista, CA 92081, or email Lsoto@vidwater.org forthwith.

PASSED AND ADOPTED by the following roll call vote of the Board of Directors for the Tri-City Healthcare District this 25th day of March, 2021.

AYES: DIRECTORS:
NOES: DIRECTORS:
ABSTAIN: DIRECTORS:
ABSENT: DIRECTORS:

_____
Rocky J. Chavez
Board President
Tri-City Healthcare District

ATTEST:

_____
Tracy M. Younger
Secretary
Tri-City Healthcare District

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
March 10, 2021

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 3/26/2021 – 2/28/2023)

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 3/26/2021 through 2/28/2023:

- **BINIUS, Tracy MD/Psychiatry (Array Behavioral Care)**
- **EVANS, Jamie MD/Psychiatry (Array Behavioral Care)**
- **IKELHEIMER, Douglas MD/Psychiatry (Array Behavioral Care)**
- **KLEIN, Michael MD/Teleradiology (StatRad)**
- **LIZOTTE, Paul DO/Internal Medicine**
- **SMITH, Richard P. DO/Psychiatry (Array Behavioral Care)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 5
March 10, 2021

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 04/01/2021 -03/31/2023)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 04/01/2021 through 03/31/2023, 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:

- ANSARI, Rashad, MD/Rheumatology/Active Affiliate
- BERMAN, Blake, DO/Neurosurgery/Provisional
- BERNHARDT, Chad, MD/Emergency Medicine/Active
- BODDU, Navneet, MD/Anesthesiology/Active
- BRAR, Karanbir, MD/Internal Medicine/Provisional
- CASTRO, Jorge, MD/Pediatrics/Active
- DAY, Richard, MD/Internal Medicine/Active
- Dougherty, Colin, MD/Emergency Medicine/Active
- D'SOUZA, Gehaan, MD/Plastic Surgery/Active Affiliate
- FARHOOMAND, Kaveh, DO/Internal Medicine/Active
- GHOSH, Tanushree, DO/Pediatrics/Provisional
- HARTMAN, Andrew, MD/Orthopedic Surgery/Active
- JACOBS, Robert, MD/Otolaryngology/Active
- KARP, Michael, MD/Pediatrics/Active
- LEE, Margaret, MD/Diagnostic Radiology/Active Affiliate
- LORENTS, Evelyn, MD/Teleradiology/Active Affiliate
- MADHAV, Kinjal MD/Sleep Medicine/Provisional
- ORDAS, Dennis, MD/Psychiatry/Active

Attachment B

- PADUGA, Remia, MD/Neurology/Active
- RYPINS, Eric, MD/General Surgery/Active
- VORA, Roshni, MD/Anesthesiology/Active
- WANG, Anchi, MD/Neurology/Active

UPDATE TO PREVIOUS REAPPOINTMENT:

- CURRY, Jason, MD/Physical Medicine & Rehab/Refer and Follow
- HAWKINS, Melissa, MD/Obstetrics & Gynecology/Active
- YOO, Frank, MD/Neurological Surgery/Active

RESIGNATIONS: (Effective date 03/31/2021 unless otherwise noted)

Voluntary:

- ARGOUD, Georges, MD/Endocrinology, Diabetes & Metabolism
- DELGADO, George, MD/Hospice & Palliative Medicine
- GILBOA, Ruth, MD/Dermatology
- GOKALDAS, Reshma, MD/Neurology
- KIM, Jieun, MD/Pediatric Ophthalmology
- LY, Justin, MD/Teleradiology
- VANFLEET, Robert, MD/Teleradiology

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
March 10, 2021

PROCTORING RECOMMENDATIONS

• JACOBS, Robert, MD	Otolaryngology
• FIALLO, Alfredo, MD	Anesthesiology
• GLASGOW, Andrew, MD	Anesthesiology
• KANE, Norman MD	Orthopedic Surgery
• LUEVANOS, Ryan MD	Emergency Medicine
• NGUYEN, Thu, MD	Anesthesiology
• POLLACK, Melanie MD	Emergency Medicine
• SUNTAY, Berk	Obstetrics/Gynecology
• YOO, Frank MD	Neurological Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
March 10, 2021

AUTOMATIC RELINQUISHMENT OF PRIVILEGES (Effective 3/26/2021, unless otherwise specified)

The following practitioners were given 18 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of March 26, 2021.

- **KANE, Norman, MD** — **Orthopedic Surgery**

VOLUNTARY RELINQUISHMENT OF PRIVILEGES (effective March 26,2021)

- **McCutcheon, Claire, MD** — **Medicine/Hospitalist**
- **PATEL, Cecil** — **Radiology**

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 25, 2021
Rady Children's Specialists Agreement for NICU ROP Testing

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

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

Area of Service: NICU - Retinopathy of Prematurity (ROP) Testing

Term of Agreement: 12 months, Beginning, April 1, 2021 - Ending, March 31, 2022

Maximum Totals:

	Monthly Cost	**Total Term Cost**
ROP Services	$3,400	$40,800
	Total:	**$40,800**

Description of Services/Supplies:

- Ophthalmic Consultation Services for NICU - Retinopathy of Prematurity (ROP) Testing
- Negotiations took place during January – March 2021, extension in place with existing contract

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

Person responsible for oversight of agreement: Candice J. Parras, R.N., Chief of Patient Care Services

Motion:

I move that TCHD Board of Directors authorize the agreement with Rady Children's Specialists of San Diego for Retinopathy of Prematurity (ROP) testing for a term of 12 months, beginning April 1, 2021, and ending March 31, 2022 for a cost of $3,400 per month, for a total cost for the term of $40,800.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: March 25, 2021
Clinical Engineering Services Proposal

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

Vendor's Name: TriMedx Holdings, LLC

Area of Service: Clinical Engineering (Biomed)

Term of Agreement: 36 months, Beginning, May 1, 2021 – Ending, April 30, 2024

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$122,090	$1,465,080	$4,395,240

Description of Services/Supplies:

- Repair service, preventive maintenance, calibration and parts for entire TCHD medical equipment inventory
- Includes maintaining all service records for the life of the equipment
- Rates are unchanged but overall cost can fluctuate due to equipment inventory changes.
- TriMedx purchased Aramark's Healthcare Technology services division in November 2018

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

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with TriMedx Holdings, LLC for clinical engineering equipment maintenance for a term of 36 months, beginning May 1, 2021 and ending April 30, 2024 for an annual cost of $1,465,080, and a total cost for the term of $4,395,240.

ADMINISTRATION CONSENT AGENDA
March 17th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Hand Off Communication Policy	3 Year Review, Practice Change	
2. Referrals to Social Services for Patients Identified to be of High Risk Policy	3 Year Review, Practice Change	
3. Release of Deceased Procedure	3 Year Review, Practice Change	
4. Substance Abuse, Patient Policy	3 Year Review, Practice Change	
5. Universal Protocol Procedure	3 Year Review, Practice Change	
Unit Specific		
Home Care		
1. Hazardous Infectious Materials Management	3 Year Review	
Medical Staff		
1. Peer Review Process: OPPE and FPPE 8710-509	Practice Change	
Surgical Services		
1. Admission Discharge Criteria Policy	3 Year Review, Practice Change	
2. Scope of Service of PACU Policy	DELETE	

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/05 **SUBJECT:** Hand-Off, Communication

REVISION DATE: 02/06, 01/08, 07/08, 04/09, 08/12 ~~**POLICY NUMBER: IV.F**~~

Patient Care Services Content Expert~~Department~~ Approval:	**~~05/17~~07/20**
Clinical Policies & Procedures Committee Approval:	**~~07/17~~07/20~~10~~10/20**
Nursing Leadership~~Executive Committee~~ Approval:	**~~07/17~~08/20~~12~~12/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/17~~08/20~~01~~01/21**
Administration Approval:	**03/21**
Professional Affairs Committee Approval:	**~~09/17~~ n/a**
Board of Directors Approval:	**09/17**

A. **PURPOSE:**

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

B. **DEFINITION(S):**

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

C. **POLICY:**

1. Healthcare providers shall use the SBAR process when providing hand-off communication.
2. Hand-off communication shall:

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

3. A consistent method for patient hand-off communication shall be conducted throughout the organization during the following:
   a. Change of shift
   b. Break relief
   c. Prior to the transfer of care to another nursing unit
   d. Prior to and after transfer of care to another department for a procedure/test, i.e. radiology, surgery, cardiac catherization, inpatient dialysis unit
   e. Prior to transferring/discharging a patient to another facility

~~4. Shift Team Update: A brief verbal communication between licensed staff (RN) and ACTs to provide pertinent information regarding individual patient assignments.~~

~~a.~~**4.** Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication.

~~b.~~**5.** Shift Team Updates shall continue throughout the shift as needed, to improve communication between all members of the health care team.

~~5.~~**6.** If patient is transported and unaccompanied by a licensed nurse, nurse shall provide a safety hand-off to the transporter.

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

1. The following references may be used to provide hand-off communications, **including but not limited to**:
   a. History and Physical
   b. Electronic Health Record (EHR) patient care applications i.e. orders, labs, vital signs
   ~~c. Electronic kardex~~
   ~~d. Electronic Medication Administration Record (eMAR)~~
   ~~e.~~**c.** Medication Administration Record (MAR)~~ summary~~
   ~~f.~~**d.** Physician's**/Allied Health Professional (AHP)** Orders
   ~~g.~~**e.** Physician's Progress Notes
   ~~h.~~**f.** Chart Summary Screen
   ~~i.~~**g.** SBAR Shift-to Shift Hand-off Communication form

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

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

a. All pertinent pre/post-surgical/procedural information
b. Whereabouts of family and belongings

F. **BREAK RELIEF:**

1. A verbal handoff should include the following information:

~~1.~~**a.** Patient information (name, age, physician, diagnosis)
~~2.~~**b.** Current condition and status (level of consciousness, vital signs)
~~3.~~**c.** Code status
~~4.~~**d.** Isolation status
~~5.~~**e.** Patient safety
~~6.~~**f.** Medications or tasks due or in progress
~~7.~~**g.** Calls placed to physicians

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

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

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

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

I. **REFERENCES:**

1. Caruso, E. (2007).The evolution of nurse-to-nurse bedside report on a medical-surgical cardiology unit. *MEDSURG Nursing, 16*(1), 17-22.
2. Maxson, P. M., Derby, K. M., Wrobleski, D. M., & Foss, D. M. (2012). Bedside Nurse-to-NurseHandoff Promotes Patient Safety. *MEDSURG Nursing*, *21*(3), 140-145.
~~2.~~**3. Müller M, Jürgens J, Redaèlli M, *et al.* Impact of the communication and patient hand-off tool SBAR on patient safety: a systematic review. BMJ Open 2018;8:e022202. doi: 10.1136/bmjopen-2018-022202**
~~3. Hand-off communications. (2007). AORN Journal, 86S146-9:10.1016/J.Aorn.2007.11.012 CINAHL Plus~~
4. Risenber, L. A., Leisch, J. & Cunningham, J. (2010). Nursing handoffs: A systematic review of the literature. *AJN, American Journal of Nursing*, 110(4), 24-34

~~5. Patient safety: "a ticket to ride" protects patients off the unit. *Nursing 2012, 39* (5), 57-58. Retrieved from http://www.nursingcenter.com/Inc?journal?Article_ID=858666~~

~~7. Patients at this hospital have a "ticket-to-ride." Healthcare Benchmarks Qual Improv. 2006; 13(9): 102-104~~

5. **Shahid, S., Thomas, S. Situation, Background, Assessment, Recommendation (SBAR) Communication Tool for Handoff in Health Care – A Narrative Review. *Saf Health* 4, 7 (2018). https://doi.org/10.1186/s40886-018-0073-1**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/85

SUBJECT: Referrals to Social Services for Patients Identified to be High Risk

REVISION DATE: 05/91, 06/94, 09/99, 06/03, 01/04, 02/07, 05/10, 09/11

~~**POLICY NUMBER: III.D.1**~~

Patient Care Services Content Expert~~Department~~ Approval:	~~09/17~~08/20
Clinical Policies & Procedures Committee Approval:	~~09/17~~10/20
Nursing Leadership~~Executive Council~~ Approval:	~~09/17~~12/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/17~~01/21
Administration Approval:	03/21
Professional Affairs Committee Approval:	~~11/17~~ n/a
Board of Directors Approval:	12/17

A. **PURPOSE:**

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

B. **DEFINITION(S):**

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

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

C. **POLICY:**

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

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

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

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**RELEASE OF DECEASED**
Purpose:	To care for and release remains of deceased to Medical Examiner's Office, appropriate mortuary/crematory or Lifesharing

A. **AFTER A PATIENT'S DEATH, THE STAFF NURSE WILL:**

1. Notify physician/Allied Health Professional (AHP) to pronounce the patient or to obtain physician's order for the Administrative Supervisor (AS) or authorized Registered Nurse (RN) to pronounce patient dead.
   a. Notification of the family of the patient's death is the responsibility of the physician/AHP.
      i. Provide next of kin's name and phone number to physician/AHP.
      ii. Ask the physician/AHP who will be responsible for signing the death certificate and complete the Expiration Record in ~~Cerner~~**electronic health record (EHR)** with this information.
   b. For neonatal deaths see Patient Care Services Procedure: Miscarriage and Stillbirth Identification and Disposition Process and Patient Care Services Procedure: Miscarriages and Stillbirth Identification and Disposition Procedure.
   c. For in-custody deaths see Progressive Care Unit Procedure: Release of a Deceased Justice Involved Patient.
2. Notify the Medical Examiner of reportable deaths within one (1) hour of death and do not remove any lines unless this is waived by the Medical Examiner. (Refer to Patient Care Services Policy: Medical Examiner Notification for criteria for reportable deaths and process for reporting). Explain procedures involved to family.
3. Indicate in the Expiration Record in ~~Cerner~~**EHR** if the Medical Examiner is notified or not.
   a. If the Medical Examiner is notified and waives the case make sure to enter the waive number in the Expiration record.
   b. If the Medical Examiner accepts the case document in ~~Cerner~~**EHR** the Medical Examiner accepts case.
   c. The Medical Examiner's office will pick up decedent.
4. Notify the donor referral line (Lifesharing) as soon as possible and within one (1) hour of the death at 1-888-423-6667 (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes – Donation Option – Brain Death). Note the date and time of this call and name of the referral line staff on the Expiration Record in ~~Cerner~~**EHR**.
   a. If LifeSharing identifies the patient as a candidate for eye, bone or tissue procurement, a Lifesharing Representative shall contact the family regarding donation options (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes – Donation Option – Brain Death) for referral, obtaining consent, and recovery process. If the representative calls back with donation information for consent purposes, the additional information on donation in the Expiration Record in ~~Cerner~~**EHR** needs to be completed.
   b. Only a Lifesharing Procurement Coordinator shall approach the family regarding donation option for organs.
      i. Verify that the family consent or refusal for donation option is documented in the Expiration Record in ~~Cerner~~**EHR** along with time of death.
      ii. Provide eye care for corneal / eye donation patients (close eyes, place light ice bags over the eyes). Corneas can be utilized up to twelve (12) hours.
      iii. Document consent for donation in the "Expiration Record" in ~~Cerner~~**EHR** and place signed consent form in the front of the medical record. Leave the chart in the Nursing area at the main nursing desk on the floor in which the patient

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
12/94, 04/07, 03/10, 06/13,12/13, 10/17, **10/20**	07/06, 04/07, 03/10, 06/13,12/13, 03/16, 10/17, **10/20**	08/06, 07/07, 04/10, 06/13,12/13, 03/16, 10/17	**n/a**	08/06, 07/07, 04/10, 07/13, 01/14, 04/16, 11/17, **01/21**	**03/21**	09/06, 08/07, 05/10, 09/13, 02/14, 06/16, 01/18, **n/a**	09/06, 08/07, 05/10, 09/13, 02/14, 06/16, 01/18

expired for the Procurement Coordinator to review. Document recovery procedure completion if done at bedside in the expiration record in the "other" comment box of "Organ Donation Approval" section.

~~5. Notify AS /specially trained RN 760-644-6968 immediately after death.~~

~~a. If the AS is not available, Security will be point of contact, until AS is available.~~

~~6.~~5. Solicit assistance from Chaplain, Social Services and/or patient's Hospice Nurse as needed for family support.

a. If hospice is involved, they do not notify the mortuary to pick up the deceased, only the AS makes this call.

b. In the Emergency Room, Social Services and Trauma Interventional Program (TIP) is available for family support.

~~7.~~6. Verify that the time of death is recorded in the Expiration Record in ~~Cerner~~**EHR** by the AS or by the physician/AHP who pronounced the death. If the AS or specially trained RN pronounces, the time will be entered into the note of pronouncement and expiration record, otherwise the time will be noted in the Physician's Progress Note **or Discharge Summary**.

~~8.~~7. Provide family information regarding funeral arrangements and support services.

~~9.~~8. Release patient belongings and valuables after recording inventory of all valuables and patient belongings in the Expiration Report in ~~Cerner~~**EHR** and then print Authority for Release of Deceased Report and place a patient label where indicated. Release belongings to family and obtain their signature on Authority for Release of Deceased Report.

a. Any unclaimed valuables will be secured in valuables envelope and then the RN notifies Security to pick up the valuables. All unclaimed valuables will be placed in the hospital safe per Patient Care Services Policy: Patient Valuables Liability and Control and the receipt forwarded to the AS. Security is to be contacted to provide patient valuables to family members when requested after a patient's death.

b. If family is not present to take patient belongings, then the RN notifies Security to pick up the belongings and place them in a secure designated location. Security is to be contacted to provide patient belongings to family members when requested after a patient's death.

~~10.~~9. Print ~~Cerner~~**EHR** report Authority for Release of Deceased Report for signatures.

a. If Authority for Release of Deceased Report is signed by a legal representative, attach a copy of the documentation of legal representation, e.g. Power of Attorney.

~~11.~~10. Forward the following to the AS :

a. A completed electronic Authority for Release of Deceased Report.

b. Facesheet – 1 copy.

c. 1 copy of documentation of legal representation of patient, i.e. Power of Attorney; Conservator, if applicable.

d. Valuables receipt.

e. Authorization for Autopsy (if requested by family or physician and financial arrangements have been confirmed with Department of Pathology).

f. Consent for Anatomical Donation, for Tissue and/or Eye Donation (when procurement is complete).

g. Body donation program acceptance letter/forms.

11. After patient is properly identified and placed in body bag, notify Lift Team to transport the body from the patient care area to the morgue for temporary storage.

~~12.~~a. **Do not send belongings to the morgue with the patient**

~~13.~~12. May also release patients to Medical Examiner's office ~~or mortuary from the patient's room~~ following the above process and sign off appropriately on the Authority for Release of Deceased Report.

B. **THE ADMINISTRATIVE SUPERVISOR WILL**:

1. Call the mortuary when the body is ready for release from Tri-City Healthcare District (TCHD) and provide them with the information requested from the completed Authority for Release of Deceased Report. Refuse release of body to any agency or transport service before hearing

from next of kin and having authorization signed. Exceptions to this are as follows:

a. The Medical Examiner will pick up the deceased on their authority.
b. If the patient has made prior arrangements (pre needs), a copy of this document from the mortuary is acceptable.

2. Send the Authority for Release of Deceased Report and additional paperwork to the AS office~~, even if patient is to be picked up from room or other areas of the Medical Center~~.
3. Notify Engineering **and lift team** when morgue bay is full to adjust temperature **and rotate the bodies. Use overflow morgue as needed**.
4. Respond to call from Private Branch Exchange (PBX) when a security officer is unavailable to release deceased from TCHD.
5. Notify Public Administrator if:
   a. Next of Kin of patient is unidentified and there is no identified court appointed Power of Attorney or Conservator/Guardian.
      i. Holding A Body Pending Disposition: The body of any person whose death occurs in this State, or whose body is found in the State, or which is brought in from outside the State, shall not be temporarily held pending disposition more than eight (8) calendar days after death, unless a permit for disposition is issued by the local registrar of the registration district in which the death occurred or the body was found.
   b. Parents or family of fetal demise have made no mortuary arrangements after eight (8) days.
      i. If parents or families are unable to financially obtain mortuary services, they may contact the Public Administrator for assistance. This is done by the family placing the call to the San Diego County Public Administrator (858) 694-3500.
      ii. TCHD staff is prohibited from making mortuary referrals or financial arrangements for families.
6. Serve as a resource to the staff nurse regarding consent for tissue, organs, and eye donation, (refer to Patient Care Services Policy: Organ Donation, Including Tissues and Eyes – Donation Option – Brain Death). The determination of donor suitability will be done by Lifesharing.
7. Contact Anatomical Gift Program to verify donation when patient has applied or been accepted into the anatomical gift program for body donation.
   a. If available, attach a copy of the acceptance forms and letter, from the University Medical Center or school to the Authority for Release of Deceased Report. If not available from the family, call the Program Office at the School or University for a copy to be faxed to TCHD and attached to the Authority for Release of Deceased Report.

~~8. In the case of an autopsy:~~
~~a. Autopsies may be requested on any deceased patient by the attending physician/AHP or immediate family/legal guardian who has legal standing, in order to determine the cause(s) of death, but only with a signed written consent, i.e., a formal Autopsy Permit, sometimes referred to as Authorization for Autopsy.~~
~~b. Ensure family understanding that the attending physician/AHP's request for an autopsy does not make TCHD financially responsible for the autopsy, and does not obligate the TCHD Pathologist. There is a professional fee from the Pathologist for the service, and the Family must make financial arrangements for the autopsy with the TCHD Pathologists prior to the start of the autopsy. The AS will assist the family in meeting with a representative of the Pathology Department to make such arrangements.~~
~~c. The TCHD Pathologist reserves the right to evaluate the indications for the autopsy, and may decline the request if it is deemed inappropriate.~~
~~i. If the autopsy is so declined by the TCHD Pathologist, the family may then elect to commission the S.D. County Medical Examiner's office (M.E.) to perform a private autopsy, if that office agrees to do so. Those private arrangements must be made directly between the next of kin with legal standing and the M.E.'s office. The Family will be financially responsible for the M.E.'s fees in these circumstances also. The M.E. would be expected to charge a fee if that office~~

~~does not exert it legal jurisdiction and convert the case to a "Medical Examiner's Case".~~

~~d. When a family requests an autopsy be performed at TCHD:~~
~~i. The patient's physician/AHP, Pathology and Medical Records are notified.~~
~~ii. All forms are signed.~~
~~iii. The chart is sent to Medical Records for processing and is forwarded to Pathology Department the same day for the autopsy.~~
~~iv. The canary copy of the autopsy consent is kept by the AS with the Authority for Release of Deceased Report copies.~~

~~e. The Secretary for the Department of Pathology notifies the AS when the autopsy is complete. The original Authorization for Autopsy form stays with the chart, a carbon copy remains in the Laboratory. Upon notification of autopsy completion, the body may be released to the mortuary.~~

~~f. For autopsies to be completed at outside facilities (e.g. UCSD Medical Center or the Medical Examiner's office), the body will be released and signed copies of the Authority for Release of Deceased Report in the space provided for such agencies and Autopsy Consent (pink copies) provided. The Authority for Release of Deceased Report will remain on the board for return of body if known. Remaining forms go to the AS.~~

~~9.~~**8.** Once the body is released from the TCHD morgue it is no longer the responsibility of TCHD to accept the body back to our morgue. Fetal demises will be released from Pathology to the mortuary of choice.

C. **THE SECURITY OFFICER WILL**:

1. Upon notice by AS of mortuary service or Medical Examiner's arrival, pick up Authority for Release of Deceased Report forms from the AS office. If no forms found, call the AS (760) 644-6968.
   ~~a. If the patient is to be picked up from their room, Security will follow the same process.~~
2. Go to the morgue or patient's room with above paper work, identify Medical Examiner's agent, appropriate mortuary service/procurement agency, and verify the deceased with all identification as below:
   a. Medical Examiner's agent: Request identification and verify the name of the decedent.
   b. Mortuary: Request identification and verify the name of decedent.
   c. Decedent: Check the Authority for Release of Deceased Report and Patient Identification Label/name against the hospital armband and bag/toe tags.
   d. Verify that no personal belongings or valuables remain on the deceased. **Any remaining belongings or values will be logged into Lost and Found by Security**~~Return all valuables and/or belongings found to AS~~.
3. Legibly sign the Authority for Release of Deceased Report along with driver.
4. Provide driver with unsigned copy of Authority for Release of Deceased Report
5. Complete Morgue Disposition Log, logging patient out of morgue (or back into morgue, if patient is returning from Medical Examiners/procurement agency).
6. Deliver signed copy of the Authority for Release of Deceased Report to the AS office and make a second copy of signed report.
   a. Place original copy on clipboard labeled Medical Records and place in Returns box, this will be picked up daily by Medical Records.
   b. Update Deceased Tracking Report with morgue status daily.
7. Notify AS when a deceased is returned to the morgue from an outside agency.
8. Notify AS if any problems with morgue, or if any deceased is not in a morgue bay with their name.
9. Update morgue log with any deceased patient movement, either entering the Morgue or being removed from the morgue.
10. At no time will any Security Officer be required to:
    a. Lift or attempt to lift any remains as assistance to the Mortuary Driver.

b. ~~No Security Officer shall be required to t~~Transport a deceased patient's remains to or from the Morgue.

~~c. If it is necessary to escort the Mortuary Driver to the expired patient's room, the floor's ANM/Relief Charge Nurse will be responsible for all paperwork.~~

~~d.~~c. ~~No Security Officer shall be required to p~~Participate in any other functions of a Morgue Release than stated in this policy.

~~e. No Security Officer shall be required to prepare a deceased patient's body for viewing in the Morgue or any other location.~~

11. Ensure there is a family consent before allowing San Diego Eye Bank to take the body from the morgue and start the case. Security should first check with the AS to ensure that consent exists.

~~D. SECURITY AFTER HOURS PROCESS:~~

~~1. AS will be the point of contact for Release of Deceased matters to include: family members signing the Authority of Release of Deceased Report, communication with mortuaries, donation services and release of remains from TCHD.~~

~~2. After Hours Procedure:~~

~~a. AS will be notified of request.~~

~~b. AS shall contact/speak with family member and verify next of kin status or right to sign.~~

~~c. Security shall request that the family member come in to sign the Authority for Release of Deceased Report.~~

~~d. Upon family signing, Security Officer will release personal belongings.~~

~~e. AS will call the mortuary of choice for notification of release.~~

~~f. AS will document on the Authority for Release of Deceased Report time, date and signature.~~

~~g. Paperwork will remain with clip board in the AS office.~~

~~E.~~D. **THE LIFT TEAM WILL:**

1. Obtain a morgue key, retrieve the covered morgue transport gurney from the morgue, and transport it to the requesting unit of a deceased patient.
   a. The patient should be in a body bag.
   b. Lift Team will assist with placing patient in body bag if patient is large.

~~2. Transport patient to and from the morgue as requested by AS to accommodate family viewing or place patient on gurney in the morgue for viewing if needed a number 1 or number 2 will be written on the back side of the Authority for Release of Deceased Report.~~

~~3.~~2. Record requested information on Morgue Disposition Log, logging patient into or out of morgue.

~~4.~~3. Notify the AS if morgue bays are full, body is not in a morgue bay, or morgue equipment is not functioning properly.
   a. AS to notify Engineering for temperature adjustment.

~~5.~~4. Rotate bodies as directed when there are more bodies than morgue bays available, under the direction of the AS.

~~a. Unclaimed bodies will be transferred to outside morgue #2 as determined by the AS.~~

~~F.~~E. **PROCESSING OF COMPLETED PAPERWORK BY ALL STAFF:**

a. Original copies of all paperwork (All Consents, authorizations, and the electronic Authority for Release of Deceased Report) will be forwarded to the AS for processing.

~~G.~~F. **MANAGEMENT OF CALLS RELATED TO RELEASE OF DECEASED ISSUES:**

1. Addressed by the patient's nurse and AS.

~~H.~~G. **DECEDENT'S PROPERTY:**

1. Except when there is reason to know of a dispute over a deceased patient's personal property, California law permits a decedent's personal property to be turned over to the decedent's residence, the patient's spouse or relative, or to the conservator of the decedent/guardian of the decedent's estate. If the estate is being administered, however, the property must be delivered

to the personal representative (i.e., executor or administrator of the will/estate) upon request of the personal representative. If no member of the family or legal representative appears within a reasonable time, or fails to respond to hospital correspondence, the hospital can deliver the property to the public administrator and obtain a receipt to be kept in the decedent's medical record.

2. The hospital may release the property promptly after the patient's death; however the recipient must provide reasonable proof of their status and identity. The hospital may rely on their driver's license, a passport, or photo identification card issued by the U.S. Government. The hospital must record the property released, and to whom the property was delivered, for a period of at least 3 years. The hospital must also obtain a signed receipt. Hospital will maintain a copy of the photo identification provided by the recipient, as well as the signed receipt, for the requisite time period.

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

1. Emergency Procedure: Deaths of Pediatric Patients
2. Patient Care Services Policy: Medical Examiner Notification
3. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes – Donation Option – Brain Death
4. Patient Care Services Policy: Patient Valuables Liability and Control
5. Patient Care Services Procedure Deceased Patient Care and Disposition
6. Patient Care Services Procedure: Miscarriages and Stillbirth Identification and Disposition Procedure
7. Patient Care Services Procedure: Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition)
8. Patient Care Services Procedure: Wasting Narcotics, Documentation in the Pyxis Machine
9. Progressive Care Unit Procedure: Release of a Deceased Justice Involved Patient
10. Security Policy: Morgue Release 224

~~J.~~I. FORM(S):

1. Authority for Release of Deceased Report - Sample
2. ~~Authorization for Autopsy - Sample~~
3. Deceased Tracking Report - Sample
4. Morgue Log – Sample

Authority for Release of Deceased Report – Sample

Test, Fred MRN: 00000547 FIN#: 6002100724

2 SSN: 487-66-5555 Room # 516

Oceanside CA 92056

Next of kin: Test, Fred **Relation:** Pt **Phone Number:** (111) 111-1111

Patient a donor: Yes

Attending Physician: Test, DME Physician

Pronounced Time: 04/04/2016 14:56 **Medical Examiner Notified:** Yes **Waive No.:** 55555

I acknowledge the receipt of personal effects (Acuso recibo de los efectos personales)

_____ _____ _____

Date (Fecha) Signature of next to kin (Firma del Pariente mas cercano) Relationship (Parentesco)

I hereby authorize Tri—City Medical Center to release the remains of (Por medio del presente documento autorizo a Tri—City Medical Center liberar los restos de) Test, Fred

Patient (Paciente)

To (Al):

Mortuary/Procurement Agency funeral home _____ _____

(Nombre del Mortuario) (Codigo de Area o # de Telefono) Phone No.

_____ _____ _____ _____

Date (Fecha) Signature of next to kin (Firma del Pariente mas cercano) Relationship (Parentesco con el Difunto) Phone Number (Codigo de Area o # de Telefono)

Physician to sign Death Certificate: Test, DME Physician **Phone:** ( ) —

Mortuary Notified Date & Time: _____ **By:** _____

Received from Tri—City Medical Center the remains of patient listed above

_____ _____ _____

Date/Time Signature of Medical Examiner/Lifesharing Release by

Returned By: _____ _____ _____

Medical Examiner/Lifesharing Agent Accepted by Date/Time

Received from Tri—City Medical Center

_____ _____ _____

Date/Time Mortuary/Procurement Agency Release by

Public Administrator Notified _____ Date/Time _____

0

Tri-City Medical Center

Authority for Release of Deceased

00000547
Test, Fred
02/02/1954 / 62 Years/Male
TCMC/Inpatient/6002100724

PLEASE MAKE COPY OF ORIGINAL WITH FAMILY SIGNATURES FOR MORTUARY PICK UP SERVICE

Authorization for Autopsy – Sample

AUTHORIZATION FOR AUTOPSY

Patient's Name: _____

Date: _____

Time: _____

1. I am one of the following persons authorized by law to direct disposition of the remains of the above-named patient.

   ❑ Patient ❑ Parent

   ❑ Spouse

   ❑ Registered d

   ❑ Child (over t for health care

   ❑ Other: _____

2. I hereby authori named patient.

3. In the hope that or preserving their lives and well-be surgeon to remove such specimens he same for such diagnostic, thera

4. This authorization shall be subject to the following restrictions: _____

5. I understand that the examining physician and other physicians are not employees or agents of the hospital. They are independent contractors.

Signature: _____

Witness: _____

Witness: _____

DELETE

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

Affix Patient Label

AUTHORIZATION FOR AUTOPSY

7520-1001

White - Medical Recs Yellow - Admin Coord Pink - Labs

Deceased Tracking Log~~Report~~ – Sample

Patients Name:	Medical Record #	Room #	Expiration Date	Expiration Time	Coroners Case (Y or N)	Organ Donation (Y or N)	Autopsy (Y or N)	Paperwork Location	Mortuary: Physician and Morticia n	Date Notified	Time Notified	Released Date	Released Time	Initials

Morgue Log Sheet - Sample

PT LOCATION IN MORGUE	PATIENT NAME	ROOM # PICKED UP FROM	MR #	DATE/TIME IN	PRINT LIFT TEAM NAME & UNIT FROM	DATE/TIME OUT	PRINT NAME

LABORATORY (Neonates/fetus)

PT LOCATION	PATIENT NAME	ROOM # PICKED UP FROM	MR #	DATE/TIME IN	PRINT NAME & UNIT FROM	DATE/TIME OUT	PRINT NAME

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01	**SUBJECT: Substance Abuse, Patient**
REVISION DATE: 06/03, 08/05, 04/09, 01/18	~~**POLICY NUMBER: III.E**~~

Department Approval:	~~09/17~~09/20
Clinical Policies & Procedures Committee Approval:	~~10/17~~10/20
Nursing Leadership~~Executive Council~~ Approval:	~~10/17~~12/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~01/21
Administration Approval:	03/21
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **POLICY:**

1. Persons receiving medical treatment for problems related to the abuse of alcohol or drugs shall also be assessed for psychological/emotional needs.
2. Appropriate consultations, referrals or plans for follow-up care related to substance abuse shall be a routine part of the treatment and discharge planning processes.
3. ~~Behavioral Health Unit~~/Social Services **and Psychiatric Liaisions** ~~staff~~ may be consulted for assistance with planning, evaluation, and referral.
4. The attending physician/Allied Health Professional shall be informed of any suspected patient substance abuse during treatment to ensure appropriate follow-up and/or treatment options are considered.
5. Psychiatric liaisons are appropriate persons to contact for a psychiatric/chemical dependency (CD) consultation **and can assess for further evaluation**.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**UNIVERSAL PROTOCOL**
Purpose:	To outline the requirements and the process of Universal Protocol for surgical and invasive procedures. This procedure is designed to enhance patient safety by ensuring proper identification of the patient and that the correct invasive or surgical procedure is performed on the correct side and at the correct site. Procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation.

A. **DEFINITION(S):**

1. Invasive Procedure: The puncture or the incision of the skin, insertion of an instrument or insertion of foreign material into the body for diagnostic or treatment-related purposes. For purposes of this policy, excluded as invasive procedures are venipuncture, arterial puncture for lab draw, nasogastric tube placement, uretheral catheter placement, and peripheral **intravenous (IV) therapy**.
2. Patient Safety: In all cases the goal of the Universal Protocol is patient safety. To that end, the site marking or time out may be deferred if the risk outweighs the benefit to the patient in a life-threatening situation.
3. Pre-Procedural Verification: The process of assuring all relevant and needed documents (e.g. history and physical, signed procedure consent form, informed consent documented by physician, physicians orders, surgery/procedure schedule, nursing assessment, pre-anesthesia assessment, labeled diagnostic and radiology test results, scans, pathology and biopsy reports, and any required blood products, implants, devices, and/or special equipment for procedure), information and equipment are available prior to the start of the procedure, correctly identified, labeled and matched to the patient's identifiers, and are reviewed and consistent with the patient's expectations and team's understanding of the intended patient, procedure, site and side. **Pre-procedural verification is completed before the patient leaves the pre-procedure i.e., nursing units or enters the procedure room.**
4. Site Marking: For purposes of this procedure, site marking is when the physician/Allied Health Professional (AHP) who has been granted privileges to perform the procedure and will be directly involved in the procedure places his/her initials at the intended site of the procedure. Marking the site may also be done by use of a special purpose armband when it is not possible/feasible to mark the actual site.
5. Time Out: For purposes of this procedure, the Time Out means that after the induction of anesthesia or administration of any pre-procedure medication (as applicable), completion of prepping and draping, and just prior to the start of the procedure (injection of local anesthesia, insertion of instrument or device, and/or incision), the staff involved with the procedure cease all other noise and activities (to the extent possible without compromising patient safety) and conduct the final assessment that the correct patient, site and procedure are identified. **A designated member of the team initiates the time out.**

B. **POLICY:**

1. The pre-operative/pre-procedure verification process occurs with the patient is awake and aware if possible (as applicable):
   a. At the time the surgery/procedure is scheduled
   b. At the time of preadmission testing/assessment
   c. At the time of admission
   d. Before the patient leaves the unit/floor
   e. In Pre-Op Hold/pre-procedure area
   f. Prior to transporting the patient to the operating/procedural room

Patient Care services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
10/08, 01/09, 09/09, 06/10, 07/12, 03/13, 09/14, 02/17, 05/18; **09/20**	10/14, 05/17, 10/18, **09/20**	08/12, 07/13, 04/14, 10/14, 06/17, 12/18, **10/20**	08/12, 04/14, 10/14, 07/17, 12/18, **12/20**	**n/a**	10/12, 6/14, 11/14, 8/17, 02/19, **01/21**	03/19, **n/a**	11/12,07/14, 01/15, 09/17, n/a	12/12, 07/14, 01/15, 09/17

g. Anytime the responsibility for care of the patient is transferred to another member of the surgical/procedural care team (including anesthesia providers), at the time of and during the surgery/procedure

2. A Time Out is performed for every surgery and invasive procedure, regardless of laterality, levels, structure, location, or setting within the hospital, including bedside procedures. Any discrepancy discovered during the time out must be resolved before proceeding with the invasive procedure/surgery.

3. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
   a. Discrepancies include any difference between the patient's verbal confirmation of the surgery/procedure to be performed, the **history and physical** (H&P), order for consent, surgery/procedural schedule, consent and imaging studies.
   b. Members of the huddle may include, but are not limited to:
      i. Physician/AHP performing the procedure
      ii. Anesthesiologist
      iii. Radiologist/Radiology Physician's Assistant
      iv. Circulating Registered Nurse (RN)
      v. Scrub RN or Operating Room (OR) Technician
      vi. RN caring for the patient in the pre-procedural area
      vii. Primary RN
      viii. Patient/patient representative
      ix. OR/Pre-procedural area charge nurse
      x. Imaging technologist
      xi. Other healthcare provider (HCP) involved in the procedure
   c. The following documents are reviewed in the huddle:
      i. History & Physical (H&P)
      ii. Order for consent
      iii. Surgery/procedural schedule (if add on for the same day, no printed schedule is required)
      iv. Consent form
      v. Imaging studies as ordered
   d. The procedure shall not progress until all discrepancies are resolved.
   e. The discussion resolving the discrepancy and the final result of the decision shall be documented in the medical record by one of the following:
      i. Physician/AHP performing the procedure
      ii. RN/Healthcare Provider
      iii. Anesthesiologist (as applicable)

C. **SITE MARKING:**

1. Process:
   a. Prior to leaving Pre-Op Hold or the pre-procedure area, the intended surgical site is marked by the physician/AHP performing the procedure. Site marking must be legible, unambiguous, used consistently throughout hospital, and visible once the patient is prepped and draped.
      i. Outpatient areas without pre-procedure areas will perform site marking in the procedure room.
   b. Site marking is required for all surgeries and invasive procedures except:
      i. Emergency situations where any delay in initiating the surgery or invasive procedure would compromise the safety of the patient or outcome of the procedure.
      ii. Single organ procedures without intended laterality.
      iii. Procedures that are intended to be bilateral and no laterality-based choice is involved.

iv. Procedures with no pre-determined site of insertion (i.e. cardiac catheterization, Interventional Radiology procedures).
v. Procedures in which the site is so clearly evident (i.e. open fracture, laceration, cast) that it cannot be confused.
vi. Procedures in which the physician/AHP performing the procedure is in continuous attendance of the patient from the point of decision to perform the procedure through the completion of the procedure.
vii. Endoscopic procedures and Bronchoscopies.

c. Site marking takes into consideration laterality, surface (i.e. flexor/extensor), level (spine) or specific lesion/digit to be treated.
d. The mark is made using a marker that is sufficiently permanent to remain visible after skin prep and the mark is to be placed such that it is visible after the patient is prepped and draped.
e. The mark is made using the physician/AHP's initials.
   i. First and last initials are used. If the first and last initials are "N.O." a third initial is used.
   ii. The physician/AHP may choose to also draw a line at the proposed incision site.
f. In the event of multiple primary procedures by different physicians/AHPs, each site must be marked prior to admission to the OR/procedural area.
g. The site marking should be done with the patient/family awake and involved, to the extent possible.
h. For minimal access procedures intended to treat a lateralized internal organ, the intended side is indicated by a mark at or near the insertion site.
i. Marking for procedures performed at the patient's bedside will occur prior to prepping/draping or starting the procedure.

2. For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative radiographic techniques may be used for marking the exact vertebral level.
3. Dental Procedures: The operative tooth name(s), number(s) and/or letter(s) are indicated on the documentation (OR schedule, H&P/plan for surgery, order for consent) and the operative tooth/teeth are marked with the physician's/AHP's initials on the dental radiographs or dental diagrams. The radiograph/diagram is posted in the procedure room prior to start of the procedure.
4. Nerve blocks: **The anesthesiologist**~~Anesthesia~~ shall confirm the surgical/procedure site, through a comparison of the patient's verbal response and a review of the medical record and procedural consent form, prior to the administration of sedation and/or initiation of a nerve block. The Anesthesiologist may place a pre-surgical nerve block only after the surgical site has been marked by the physician/AHP.
5. Special Use Armband:
   a. A special use armband is used when the surgical site is required to be marked, but cannot be marked because of one of the following situations:
      i. The patient refuses
      ii. The patient is a neonate
      iii. The proposed site is technically or anatomically difficult to mark (e.g., perineum)
      iv. Movement of the patient to mark could compromise the safety of the patient or outcome of the procedure (e.g. patient with unstable spine fracture)
   b. The first and last name of the patient, a second patient identifier, and the planned procedure, including site and side, are written on the armband. In the event of laterality, the armband is applied on the side of the intended procedure.
   c. The physician/AHP must initial the armband.
   d. The armband is removed at the conclusion of the procedure or immediately prior to prepping if necessary to perform the surgical/procedural prep on the banded limb.

D. **SCHEDULING:**

1. Scheduling for the procedure must include the following information:
   a. Patient name and second patient identifier (**date of birth** [DOB], **medical record number** [MRN], or **financial identification number** [FIN]). Cases cannot be scheduled unless this information is available (with the exception of an emergency, when a delay procuring information could adversely affect the patient).
   b. Entire procedure, exact site, level, digit and side/ laterality. No abbreviations may be used.
   c. See department specific scheduling procedures for additional scheduling requirements.

E. **PRE-PROCEDURE VERIFICATION PROCESS:**

1. Upon admission, the patient's identity is verified by the person admitting the patient. An appropriate identification band is affixed to the patient's arm (or leg). See Patient Care Services Policy Identification, Patient.
2. Before the patient leaves the unit/floor the Registered Nurse (RN):
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P (must be electronic or printed within 30 days prior to surgery/procedure)– review the plan for surgery
      ii. Electronic H&P update completed day of surgery/procedure ~~(i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)~~
      iii. Orders for consent
      iv. Consent form
      v. Surgery/procedural schedule
      vi. Imaging studies report (as applicable)
   b. Completes the ~~pre-operative/~~pre-procedure checklist (as applicable).
   c. Ensures site marking is completed if patient is going directly to the operating room.
   d. Any discrepancies identified during the pre-procedure verification process shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
3. In Pre-Op Hold/pre-procedure area the pre-procedural RN/HCP:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P (must be electronic or printed within 30 days prior to surgery/procedure)– review the plan for surgery
      ii. Electronic H&P update completed day of surgery/procedure ~~(i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)~~
      iii. Orders for consent
      iv. Consent form
      v. Surgery/procedural schedule
      vi. Imaging report and images, as ordered
   b. Reviews the ~~Pre-Operative Checklist~~**pre-procedure checklist** to ensure accuracy and completeness.
   c. Ensures site marking is completed.
   d. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.
4. Prior to transferring the patient to the operating room/procedural area the OR/Procedural RN:
   a. Reviews the medical record to verify the following items are available, accurately matched to the patient and are all in agreement for the procedure/site/side to be performed:
      i. H&P (must be electronic or printed within 30 days prior to surgery/procedure)– review the plan for surgery

ii. Electronic H&P update completed day of surgery/procedure ~~(i.e., Physician Pre-Procedure Documentation form in the Electronic Health Record)~~
iii. Orders for consent
iv. Consent form
v. Surgery/procedural schedule
vi. Imaging report and images, as ordered

b. Reviews the ~~Pre-Operative Checklist~~**pre-procedure checklist** to ensure accuracy and completeness.
c. Ensures necessary implants or special equipment are available.
d. Ensures site marking is completed.
e. Any discrepancies identified during the pre-procedure verification process, shall require a "hard stop" and a "huddle" to be called at the patient's bedside to resolve the discrepancy.

F. **TIME-OUT**:

1. The Time Out is conducted immediately before starting the procedure.
2. During the Time Out, all other noise and activities in the room are suspended (to the extent possible, without compromising patient safety).
3. Use the medical record and patient armband to verify:
   a. Patients' identity verified using two patient identifiers per Patient Care Services: Identification of Patients Policy and comparing two sources of identification (patient's armband, if visible, and medical record). If the armband is not visible during the Time Out, one of the following alternatives must be used:
      i. A patient identification band is placed on an exposed extremity (alterative wrist, ankle) and this band is used to confirm two patient identifiers during the Time Out.
      ii. Two team members confirm the patient identity (two identifiers) upon arrival to the surgical/procedural area. One of the team members must remain with the patient during the entire pre-procedural phase and confirm the patient identity during the Time Out.
      iii. Two team members confirm patient identity (two identifiers) upon arrival to the surgical/procedural area. The two patient identifiers are written on the white board in the procedure room and confirmed by the two team members. During the final Time Out, the team confirms patient identity against the information on the white board.
         1) This patient identification process shall be used in surgical services.
   b. Physician/AHP calls for the Time Out after the patient is prepped and draped.
   c. All personnel in the OR/procedure room introduce selves by name and role.
   ~~c.~~**d.** The circulating RN/assistive HCP (such as Emergency Medical Technician, Respiratory Care Practitioner, Radiology Technician, Anesthesia Technician):
      i. Uses the consent form to read the patient's name, approved second identifier, and procedure **(including site and side)**.
      ii. Verifies all sterility indicators were checked, as applicable.
      iii. Reviews equipment issues or concerns.
      iv. States the Fire Risk Assessment score.
      ~~ii.~~**v.** Verifies the following precautions were taken when using alcohol-based prep solutions:
         1) At least 3 minutes passed for prep to dry and fumes dissipated before draping or using surgical equipment.
         2) Prep solution is not pooled.
         3) Prep solution-soaked materials are removed from the field prior to draping or using surgical equipment.
   e. The anesthesiologist (if applicable, or circulating RN if no anesthesiologist present):
      i. ~~s~~States antibiotic administered, dose and time.

~~d.~~**ii. Reviews any patient-specific concerns.**

~~e. The circulating RN/assistive HCP:~~

~~i. Verifies antibiotic selection is appropriate to procedure~~

~~ii. States antibiotic re-dosing interval~~

~~iii. Sets a timer for 30 minutes less than the re-dosing interval (i.e., if the re-dosing interval is 2 hours, set the timer for 1 hour and 30 minutes)~~

f. The **surgeon/procedural** physician/AHP:

i. ~~states the intended procedure, v~~Verifies the site is marked (if applicable)

ii. Verifies essential imaging is displayed

iii. Reviews critical or unexpected steps in the procedure

iv. States anticipated operative duration

v. States anticipated blood loss

~~f.~~**vi.** ~~and a~~Asks if all agree~~.~~

g. The scrubbed person states agreement and readiness for consented procedure.

h. All Staff members in the OR at the time of the time out must state "I Agree" or state their concern/discrepancy.

4. Initiation of the Time Out is the responsibility of the physician/AHP performing the procedure.

5. The Time Out is conducted in a fail-safe mode:
   a. The surgery/invasive procedure is not started until all questions are resolved.

6. The time out includes all members of the procedural team who will be participating in the procedure at its inception.

7. The ~~circulating RN or healthcare provider assisting the physician/AHP is responsible for documentation of the~~ Time Out **is documented** in the patient's ~~medical~~ **electronic health** record.

8. If two or more procedures are being performed on the same patient, a Time Out is performed to confirm each subsequent procedure before it is initiated.

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

1. Patient Care Services: Identification of Patients Policy

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

1. JAMA Surgery (2017). Centers for disease control and prevention guideline for the prevention of surgical site infection, 2017. *JAMA Surgery*, E1-E8. doi: 10.1001/jamasurg.2017.0904

2. The Joint Commission. (201~~7~~**20, July**). **National patient safety goals effective July 2020 for the hospital program. Retrieved from https://www.jointcommission.org/standards/national-patient-safety-goals/hospital-2020-national-patient-safety-goals/**

~~2.~~3. ~~*Hospital Accreditation Standards.* Illinois: Joint Commission Resources./~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 3/06~~
~~SUBJECT: HAZARDOUS INFECTIOUS MATERIALS MANAGEMENT~~
~~REVISION DATE: 10/06,10/08~~
~~POLICY NUMBER: 503~~
~~REVIEW DATE: 11/06, 10/08, 6/11~~
~~APPROVAL: 4/06, 11/06, 11/07, 2/09, 9/11~~

ISSUE DATE: 03/06

SUBJECT: Hazardous Infectious Materials Management

REVISION DATE(S): 04/06, 11/06, 11/07, 02/09, 09/11

POLICY NUMBER: 503

Home Health Care Approval:	06/20
Infection Control Committee Approval:	08/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/21
Administration Approval:	03/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide a policy delineating the process of the storing and disposal of hazardous infectious waste in the Home Health environment.

B. **POLICY:**
1. It is the policy of the Agency to protect both the patient and staff by providing guidelines for the proper disposal of infectious waste and sharps in the patient's home, and the storage of infectious waste in the Agency that protects both patient and staff.

C. **PROCEDURE:**
1. Unused sharps containers are stored in a locked cabinet in the front office area. Two unused sharps containers are stored in the Pyxis for emergency use. Staff requiring a sharps container must log the numbered container in the logbook and sign their name and date of receipt. This is monitored by two designated office staff with keys to the locked container. When the container is dispensed, the Tri-City Medical Center ID sticker is placed on the container and the "open" date is written on the container in indelible ink.
2. When the container is two-thirds full it is returned to one of the two designated office staff maintaining the log. The designated office staff individual will then write the "closed" date on the container and place a label over the opening indicating the open and closed date. The designated staff member then transports the used container to the Tri-City Radiation department for containment and disposal. All employees transporting sharps must carry a copy of the Medical Waste Management Plan.
3. All infectious material generated in the patient's home is disposed of in accordance with the California Health and Safety Codes prohibiting the disposal of "home generated sharps waste," such as hypodermic needles, pen needles, intravenous needles, and lancets, in trash or recycling containers. It requires that all sharps waste be transported to a collection center in an approved sharps container. Information regarding sharps disposal is in the Tri-City Home Health Patient Admissions Booklet.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**01/07**	**SUBJECT:**	**Ongoing Practice Evaluation: OPPE & FPPE ~~Peer Review Process: OPPE and FPPE~~**
REVISION DATE:	**03/08, 05/08, 06/08, 07/15, 07/17**	**POLICY NUMBER:**	**8710 – 509**

Medical Staff Department Approval:	**~~03/20~~01/21**
Medical Staff Committee Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~01/21**
Administration Approval:	**~~04/20~~03/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**

1. **To provide guidelines for the Medical Staff to identify competency and professional practice trends that impact quality of care and patient safety which may require intervention by the organized medical staff. The information used in the Ongoing Professional Practice Evaluation (OPPE) evaluation may be acquired through the following three components:**
   a. **Ongoing Professional Practice Evaluation (OPPE) (To include Direct Observation)**
   b. **Individual Case/Peer Review**
   c. **Focused Professional Practice Evaluation (FPPE)**

B. **POLICY:**

1. **The Medical Executive Committee (MEC) has oversight of the Ongoing Professional Practice Evaluation (OPPE) process. The Medical Quality Peer Review Committee (MQPR) is a multi-specialty committee that evaluates and monitors the quality and appropriateness of healthcare services provided to patients and recommends plans for improving and sustaining quality patient care on an ongoing basis to the MEC.**
2. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.
3. **Members of the medical staff will receive provider-specific feedback on an ongoing basis via the OPPE process.**
4. **OPPE information in the individual practitioner's file is available to authorized individuals with a legitimate reason for access based on their assigned responsibilities. Individuals with access to provider-specific information is limited to:**
   a. **The specific provider**
   b. **Chief of Staff and Medical Staff Department/Division Chair**
   c. **Members of the MEC and Credentials Committee for purposes of considering**

appointment, re-appointment, privileges or corrective action

d. **The Board of Governors for the specific purposes associated with this policy and their role in approving members of the Medical Staff**

e. **Specific medical and hospital staff that support the work of the Medical Staff in carrying out the duties associated with this policy**

~~a.~~f. **Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g. The Joint Commission or state/federal regulatory bodies).**

~~2.~~5. **MQPR meeting minutes will be reported through the MEC meeting for approval.**

C. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. **Definition: A Summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior.**

~~1.~~2. Ongoing Evaluation: At eight (8) month intervals, every Practitioner will undergo ongoing evaluations defined by each Department/Division. Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists that requires a focused evaluation; or 3) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 4) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 5) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:

a. Patient Care
b. Medical / Clinical Knowledge
c. Practice-based learning and Improvement
d. Interpersonal and communication skills
e. Professionalism
f. Systems / Based Practice

3. **After OPPE review is completed by the respective Department/Division chair, the Practitioner receives a letter with the review findings and a copy of the OPPE file is placed in the Practitioner's file.**

~~i.~~D. **INDIVIDUAL CASE REVIEW/PEER REVIEW:**

1. **Definition: An assessment of a practitioner's professional performance by other practitioners through the review of individual patient record(s). The review can identify a provider's strengths and opportunities for improvement.**

2. **The MQPR, a multidisciplinary committee, serves as the formal peer review committee for all departments and divisions. The work of the MQPR does not preclude case discussions at department/division/committee meetings for purposes of shared learning.**

~~b.~~3. ~~Routine Individual Case Review is~~**Case reviews are** initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii) performance varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from regulatory bodies, accreditation agencies or third party payors involving quality of care, or if an appropriate, (vi) medical staff officer determines a need.

~~c.~~4. **Case** ~~R~~**r**eviews ~~: will~~ **will** be performed by the applicable department/~~,~~division ~~or committee~~ (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical Quality/Peer Review Committee (MQPR). ***Refer to attachment A (Quality Case***

Review Flowchart) **for details regarding review process for cases with suspected or identified quality of care concerns.**

~~d.~~**5.** Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the MQPR and Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

~~e.~~**6.** Reporting Findings: The findings of peer review activities are reported through the ~~department/division/quality review committee to the~~ MQPR Committee and on to the Medical Executive Committee ~~within forty-five (45) days of completion.~~ **following each MQPR meeting.**

7. Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

~~f.~~**8.** **External Peer Review: There are circumstances which can potentially warrant external peer review (e.g. ambiguity, conflict of interest, lack of internal expertise). Cases recommended for external review must be approved by the MEC. External peer review will be performed by a contracted peer review organization that is board certified and in active practice. The external peer review report is forwarded to the MQPR for review, discussion and file case disposition.**

~~D.~~E. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

~~2.~~**1.** **Definition:** ~~FPPE includes M~~monitoring, proctoring and focused review ~~activities. These~~ **activities utilized** ~~activities are intended~~ to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.

~~3.~~**2.** Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.

~~4.~~**3.** Proctoring:

a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.

b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.

c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.

~~5.~~**4.** Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are

not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or -standards; -action by a licensing agency or other governmental entity; a significant pattern of -malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MQPR Committee -and MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the -FPPE may include but is not limited to periodic chart review, concurrent chart review, direct -observation, monitoring diagnostic and treatment techniques, interviews with staff.

b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring.

c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing ~~within five business days~~. The initial written notice shall include a statement of facts -demonstrating the request for FPPE was reasonable and warranted. This communication must also -include what is wrong with the performance and what improvements are expected.

d. **-OUTCOME OF FPPE: A summary of findings and conclusion is forwarded to the MEC for review. If actions are recommended, the department/division chair is involved in reviewing the FPPE findings and formulating the proposed action plan. The Practitioner will be notified in writing of conclusions and recommendations following FPPE.**

~~E.~~**F. GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:**

1. Participants in the Peer Review Process:
   a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.
   b. Reviewer(s): The Department/Division/~~Committee~~ Chair/Chief shall appoint Practitioners to perform case **reviews**~~screening~~. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.
   c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.
   d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.
2. Data Sources/Collection: The cases for peer review are derived from quality review reports, ~~e.~~a. patient satisfaction surveys, department specific criteria and reports generated from coded medical records.
~~2.~~3. Criteria shall be reviewed by each department/~~committee/~~ **division** annually. The criteria can be changed before the annual review with request from Department Chair.
   ~~f. Cases involving more than one discipline are referred to other areas for additional input or action. These are tracked in the original committee until completed.~~
   ~~g. Incomplete case reviews are referred to the next scheduled meeting.~~

~~h. Cases referred for review shall be reviewed by the Practitioner screener of each committee (or designee), who shall determine whether to refer the case to the full committee for discussion, and make the preliminary assignment of category.~~

~~i. Cases referred for discussion shall be summarized in sufficient detail to ascertain the salient facts of the case, the issue under discussion, and the reasoning underlying the committee(s) decision.~~

4. **The MQPR will meet as necessary to conduct business; generally monthly but no less than 10 times per calendar year.**

~~j.~~5. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.

~~k.~~6. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of MQPR Committee and may require direct intervention.

~~l.~~7. **Systems or Process Concerns identified during a case review/discussion will be noted in the Peer Review minutes and referred to the appropriate personnel for further evaluation and action as appropriate. MQPR will track systems/process issues through completion.**

~~m.~~8. For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

~~F.~~G. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are casually related to the patient, to support care provided within the hospital, or care provided outside the hospital. Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may demonstrate trends useful for departmental or hospital wide management.
2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. In each occurrence below, the physician will be notified:
      i. Minimal Variance
         1) These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, and which might be to the detriment of the patient. There could be review, response or further study by the committee.
      ii. Moderate Variance
         1) These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department to the detriment of the patient. There must be review, response, trending, or further study by the committee.
      iii. Significant Variance
         1) These events represent gross departures from expected standards, raise immediate questions about judgment or technique and require an immediate response from the committee or department. In each occurrence, the physician will be notified.
      iv. Violation of Hospital Policy Includes poor communication or inadequate documentation.
      v. Violation of Physician Code of Conduct These behavioral events will initiate an immediate response. The physician will be notified.

~~G.~~H. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a

particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.

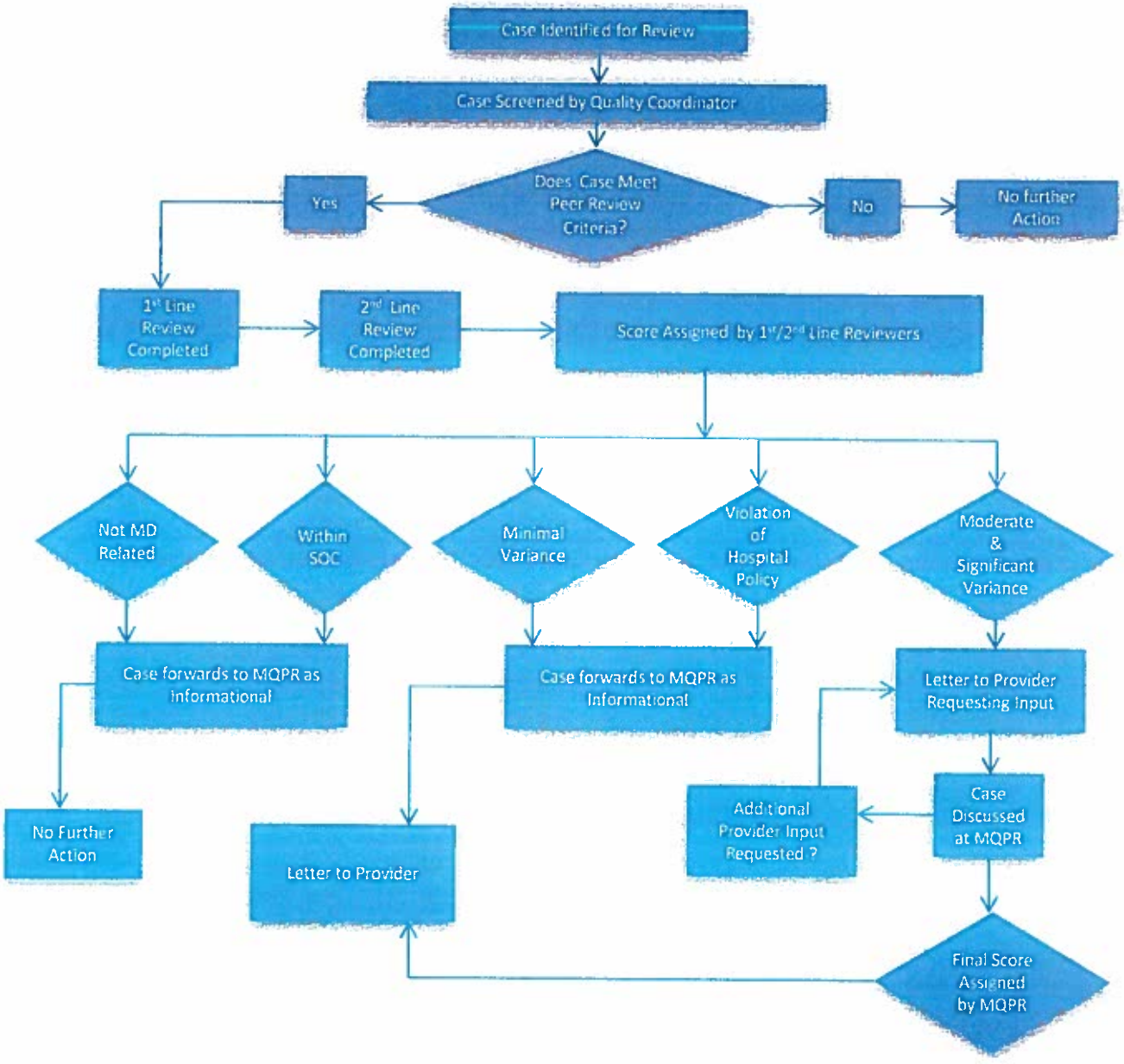
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the MQPR Committee shall serve as the appeal review body and the MEC as the final appeal body.
3. The Medical Staff member may review his/her file on request as outlined in the Medical Staff Bylaws.
6. ~~MQPR Committee oversees and supervises all medical staff peer review activity. When a subsidiary peer review body is not performing appropriately, the MQPR Committee is responsible for resolving issues.~~
7. ~~When the MQPR Committee disagrees with an assigned significance category, the case will be referred back to the Department Quality Peer Review Committee for reconsideration. If no agreement is reached, referral will be made to the Medical Executive Committee for final arbitration.~~
4. Any evaluation of a quality event that is not completed within six (6) months of initial review will be reported to the MQPR Committee and may be subject to assessment by the committee chairperson.

~~H.~~I. REFERENCES:

1. Medical Staff Standards, Joint Commission 2017
2. Effective Peer Review A Practical Guide to Contemporary Design, 3rd Edition, Robert Marder, May 2013

Attachment A

Quality Case Review Flowchart



*Peer Review Cases are Tracked/Trended through the OPPE Process
*MQPR Identified Systems Issues are Referred to the Responsible Individual(s) for Evaluation and Action
*MQPR identified Systems/Process Issues are Tracked by MQPR though completion

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
SURGERY

ISSUE DATE: 02/04 **SUBJECT: Admission / Discharge Criteria**

REVISION DATE(S): 07/06; 06/09; 09/12; 06/14; 06/16

Department Approval:	~~07/14~~02/20
Operating Room Committee Approval:	~~02/16~~03/20
Department of Anesthesiology Approval:	~~02/16~~11/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/16~~01/21
Administration Approval:	03/21
Professional Affairs Committee Approval:	~~06/16~~ n/a
Board of Directors Approval:	06/16

A. **PURPOSE:**
1. To provide guidelines for admission and discharge of patients to or from the Operating Room.

B. **DEFINITION(S):**
1. Operating Room: A specially equipped and staffed unit designed to meet the surgical needs of patients within the defined Scope of Service.

C. **POLICY:**
1. The Medical Staff shall be defined by administration.
2. All hospital personnel rendering patient care in surgery are skilled in performing basic perioperative care and equipment operation related to their position descriptions.
3. Additional training is provided for personnel in specialty areas.
4. The admission of patients to Surgical Services is based on physician-determined surgical need.
   a. Patients admitted to surgery for elective scheduled procedures must have orders for preoperative admission available to the hospital per surgery scheduling guidelines.
   b. Patients admitted to surgery from the Emergency Department or Inpatient/Outpatient areas must be seen by their surgeon and consent for surgery obtained prior to transportation from the ED or Inpatient/Outpatient Area to the Operating Room/Pre-op Holding Area.
   c. On admission to Pre-op Hold/Surgery, the following documents shall be present: (Note: Patients will not be taken into the Operating room if required documentation is missing from the chart):
      i. Correctly completed consent form(s)
      ii. History and Physical~~, written, dictated~~ (must be viewable in electronic medical record) or updated within the 24 hours prior to the procedure
         1) For complete History and Physical requirements, see Medical Staff Policy "Medical Record Documentation Requirements".
      iii. Physician Pre-Procedure Documentation form
      iv. Physician Orders
      v. Completed Preoperative Checklist
      vi. Other documents may include but are not limited to:
         1) Anesthesia Questionnaire
         2) Anesthesia Consent
         3) Results of lab work and any other diagnostic tests per physician's orders

4) Previous medical record

d. For cases requiring surgical site marking (per Patient Care Services Procedure "Universal Protocol"), the surgical site must be marked by surgeon prior to transporting patient to the OR.

e. Endoscopy procedures performed with RN-administered moderate sedation: refer to Patient Care Services Procedure "Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures" for complete pre-operative requirements.

f. The requirements above do not preclude rendering emergency surgical care to a patient in dire circumstances.

~~g. Routinely performed outpatient procedures may include, but are not limited to:~~
- ~~i. Cosmetic Surgery Procedures~~
- ~~ii. Laparoscopic procedures~~
- ~~iii. Hernia Repair~~
- ~~iv. Appendectomy~~
- ~~v. Cholecystectomy~~
- ~~vi. Hemorrhoidectomy~~
- ~~vii. D&C~~
- ~~viii. Cold Cone~~
- ~~ix. Hysteroscopy~~
- ~~x. ENT~~
- ~~xi. Cystoscopy~~
- ~~xii. Tubal Ligations~~
- ~~xiii. Arthroscopic~~
- ~~xiv. Ophthalmic~~

~~h. Anesthesia administered includes, but is not limited to:~~
- ~~i. General Anesthesia~~
- ~~ii. Regional Anesthesia~~
- ~~iii. Monitored Anesthesia Care (MAC)~~

~~i.~~5. Patient care is assigned to personnel ~~based on the individual needs of the patient~~**with at least two surgical team members, one of which is the Registered Nurse circulator.**

~~j. Each patient is assigned at least 2 surgical team members, 1 of which is the Registered Nurse circulator.~~

~~k. Procedures requiring additional resources, due to severity of illness of the patient or complexity of the procedure, shall be staffed with additional personnel.~~

~~5.~~6. Patients shall be discharged from the Operating Room by the surgeon and/or anesthesiologist upon completion of the surgical procedure.

a. The post-operative level of care is determined by the surgeon and/or Aanesthesiologist.

b. Discharge to a level of care other than what was anticipated shall be communicated to all involved parties as early as possible.

c. Information related to the patient's post-operative assessment and plan of care shall be communicated to the receiving unit by the anesthesiologist and ~~OR~~ **Surgery** RN.

d. Post-operative transport shall be directed by the surgeon and/or anesthesiologist (when applicable) and involve the appropriate personnel and equipment to safely transport the patient.

i. Endoscopy patients receiving RN-administered moderate sedation shall be transported by the RN to the designated recovery area, as determined by the procedural physician.

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into Scope of Service for Surgical Services

PERI-ANESTHESIA NURSING SERVICES POLICY MANUAL

SUBJECT: SCOPE OF SERVICE FOR PACU

ISSUE DATE: 10/11 **REVISION DATE:**

Department Approval:	**03/20**
Department of Anesthesiology Approval:	**11/20**
Operating Room Committee Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**01/21**
Administration Approval:	**03/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. ~~**PURPOSE:** To describe the Scope of Service for the Post Anesthesia Care Unit (PACU) department at Tri-City Medical Center.~~

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

~~1. GOALS~~

~~a. To improve the general health and well-being of patients who require post-surgical or post-procedural care.~~

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

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

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

~~a. The PACU provides nursing care to patients requiring post-anesthesia recovery from a variety of surgical and endoscopic procedures 24 hours a day, 7 days a week.~~

~~b. Recovery services are provided to both inpatients and outpatients.~~

~~c. Most diagnostic services are provided at the bedside, including, but not limited to: 12-lead EKG, portable x-rays, lab draws, PT/OT therapy, and rehab instruction. For other tests such as CT, MRI or invasive radiologic exams, patients are transported to the Radiology Department.~~

~~d. Other treatments and procedures performed at the bedside include, but are not limited to: cardioversions, TEE's, ultrasounds and nerve blocks.~~

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

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

~~b. The PACU RN receives hand-off report from the surgical/procedural RN and the anesthesia care provider (when applicable).~~

~~4. SCOPE OF SERVICES~~

~~a. Types of patients recovered include, but are not limited to: orthopedic, thoracic, vascular, neurosurgical, urologic, gynecological, anesthesia, plastics, otolaryngolic, ophthalmologic, oral surgery, endoscopic, robotic and general surgery.~~

~~b. PACU is a sixteen bay unit, including two cubicles enabled to act as isolation rooms, located within the surgical pavilion.~~

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

~~5. STAFFING AND AVAILABILITY OF STAFF~~

a. Sufficient staffing is maintained at all times in terms of number of personnel, skill mix, and competency to meet the needs of the patients in the PACU. Standby and call-back will be utilized to additionally staff those shifts that have minimal staffing in-house. On-call staff is available to cover the night shift.

b. Staffing is maintained in a nurse-to-patient ratio of 1:1 or 1:2, depending on patient acuity, and a charge nurse is staffed Monday-Friday from 6:30am to 11:30pm.

c. Medical care for the patient is provided by surgeons, anesthesiologists, hospitalists, intensivists and cardiologists.

d. Other multi-disciplinary team members include respiratory care, case management, pharmacy, dietary and the patient care representative.

6. PATIENT POPULATION & INTERNAL & EXTERNAL CUSTOMER DESCRIPTION

a. Pediatric, adult, and geriatric patients requiring recovery post-surgery or procedure.

b. Limitations apply to inpatient pediatric patient selection. For complete pediatric patient guidelines see Surgical Services Policy #7420-100: Scheduling Surgical Procedures.

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

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

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

a. The recovery services provided by PACU meet the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population.

8. PERFORMANCE IMPROVEMENT (PI)

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

b. PI data is posted in the department.

c. PACU PI Committee meet every other month, with minutes maintained in the binder in the PACU clean utility room.

9. STANDARDS OF PRACTICE

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

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

10. MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT

a. Medications, general and narcotics, are dispensed via the Pyxis system. Medications requiring refrigeration are stored at the appropriate temperature.

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

c. All medications administered are documented on the electronic Medication Administration Record (eMAR) for inpatients, and on the paper recovery flow sheet for outpatients.

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

February 26, 2021 – 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 January 28, 2021.

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

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi S. Gleason
Director Leigh Anne Grass
Director Adela I. Sanchez

Absent was Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Dr. Gene Ma, Chief Medical Officer
Roger Cortez, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Mark Yamanaka, Chief of Staff
Jeffrey Scott, Board Counsel
Karren Hertz, Senior Administrative Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Rocky Chavez, called the meeting to order at 3:30 p.m. via teleconference with attendance as listed above.

2. Approval of Agenda

   Chairperson Chavez requested a modification to today's agenda and requested Board Committee Assignments be struck from the Consent Agenda due to an administrative error.

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

3. Pledge of Allegiance

   Director Coulter led the Pledge of Allegiance.

4. Public Comments – Announcement

Chairperson Chavez read the Public Comments section listed on the February 26, 2021 Regular Board of Directors Meeting Agenda.

Camille Bryan, RN requested to speak under Public Comments.

Director Tracy Younger joined the meeting.

5. January 2021 Financial Statements – Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $185,449
- Operating Expense - $198,611
- EBITDA - $5,819
- EROE – ($2,782)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 155
- Adjusted Patient Days – 58,615
- Surgery Cases – 3,316
- ED Visits – 24,802

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

- Operating Revenue – $26,711
- Operating Expense - $30,974
- EBITDA - $2,344
- EROE – $1,109

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

- Average Daily Census – 180
- Adjusted Patient Days – 9,172
- Surgery Cases – 434
- ED Visits – 3,281

- Net Patient Accounts Receivable - $38.7
- Days in A/R – 51.8

6. New Business – None

7. Old Business – None

8. Chief of Staff

a) Consideration of February 2021 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on February 22, 2021.

Dr. Mark Yamanaka, Chief of Staff stated there are no additions or revisions to the Credentials as presented.

It was moved by Director Coulter to approve the February 2021 Credentialing Actions Involving the Medical Staff as amended by the Medical Executive Committee on February 22, 2021. Director Younger seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Gleason, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

9. Consideration of Consent Calendar

Director Chavez pulled item (h) Consideration to approve an agreement with Kaiser Foundation Hospitals, San Diego to provide Emergency Medicine Resident trainees for a term of 51 months, beginning March 1, 2021, through June 30, 2025.

It was moved by Director Coulter to approve the Consent Calendar as amended. Director Grass seconded the motion.

The vote on the main motion minus the item pulled via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Gleason, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. Discussion of items pulled from Consent Calendar

Mr. Steve Dietlin, CEO explained we have been expanding our relationship with Kaiser over the last year for the first time in a decade. We will be having Kaiser Residents come and train with our Emergency Department physicians and it is a welcome addition and we look forward to treating more of our community and that includes Kaiser patients.

Chairperson Chavez stated he asked the CEO to discuss this item as it is one of our strategic moves that we will be doing and he wanted to highlight that for all the Board members.

Director Grass moved to approve an agreement with Kaiser Foundation Hospitals, San Diego to provide Emergency Medicine Resident trainees for a term of 51 months, beginning March 1, 2021, through June 30, 2025. Director Younger seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Gleason, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

11. Comments by Members of the Public

Chairperson Chavez recognized Camille Bryan, RN. Ms. Bryan commented on the CNA contract that will be expiring in April and the urgent and pressing needs that need to be addressed in the areas of patient care, health and safety and nurse recruitment and retention.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO provided a report on the COVID-19 pandemic. He stated in January we had over 100 inpatient COVID-19 positive patients and approximately 90% of our ICU beds were filled with COVID patients as well. Today we have 31 positive COVID-19 inpatients.

Mr. Dietlin also commented on the success of the vaccination clinics and expressed his appreciation to everyone involved. He read excerpts of comments from grateful patients. He noted the Auxilians have also been vaccinated and have returned to assist the Medical Center.

He commented on efforts that were put in place to ensure safe patient care including the hiring of 25 Travelers. He emphasized that the health and safety of all our workers and the Medical Staff is at the forefront. He assured the nurses that comments made earlier related to patient care, health and safety and recruitment and retention are taken very seriously.

In closing Mr. Dietlin expressed his appreciation to nurses, physicians, ancillary staff and all frontline workers for their dedication and support during this pandemic.

He also recognized Board member Dr. Nina Chaya for her assistance in the clinic.

13. Board Communications

Director Gleason stated she would like to continue to applaud the hospital staff for the great work they are doing at the vaccination clinic. The rave reviews continue and the public is so thankful. She expressed her appreciation to everyone involved.

Director Chaya stated it has been such a positive experience going down to the clinic interacting with our community and seeing how much they appreciate what we have done for them and the efficiency in which the clinic is handled. She expressed her appreciation to everyone who has made the clinic such a positive experience.

Director Sanchez expressed her appreciation to everyone for doing their part, both seen and unseen. She thanked Ms. Bryan for her comments and stated we will do everything in our means to retain our experienced staff and collaborate with them to make the best decisions for our patients.

Director Coulter stated he totally agrees with everyone's comments and we have a great man Steve Dietlin at the helm. Director Coulter stated he still carries the pride in his chest that he first started experiencing in 1983 when he joined Tri-City as an employee.

Director Younger also echoed everyone's sentiments. She stated she continues to get such positive feedback about the vaccination clinics and also thanked Dr. Chaya for volunteering as a vaccinator at the clinic.

Director Younger thanked Ms. Bryan for her comments. She stated she looks forward to successful negotiations.

Director Grass reminded the community that March 30th is National Doctor's Day. She stated this special day was first observed on March 30, 1933 and then in 1990 President George Bush designated that March 30th of every year would be observed as National Doctor's Day. She expressed her appreciation to all the physicians at Tri-City Medical Center for the excellent care that is provided for the Tri-City community. She also expressed her appreciation to Dr. Chaya for administering her second COVID vaccine this past Friday.

Director Grass reminded everyone that March is National Social Worker month. She stated the social workers are an important part of the interdisciplinary team and they bridge the gap between the patients and the clinical staff, the family, social resources and government services.

Lastly, Director Grass expressed her appreciation to the nurses as well. She stated she knows Administration is very dedicated to doing the right thing for patients, families, the hospital and the community.

14. Report from Chairperson

Chairperson Chavez reported on the Board Committee assignments that were discussed at last month's Board meeting. He stated he enlisted the help of Board attorney Jeff Scott in refocusing the committees. Chairperson Chavez appointed the following Board members to the respective committees:

- Finance, Operations & Planning Committee
  Chairperson – Leigh Anne Grass
  Board Member – Dr. Nina Chaya
  Board Member – Adela Sanchez
  Board Member Alternate – Tracy Younger
  Physician Members: Chief of Staff, Chief of Staff Elect and immediate past Chief of Staff

- Audit, Compliance & Ethics Committee
  Chairperson – Gigi Gleason
  Board Member – George Coulter
  Board member – Tracy Younger
  Board Alternate – Rocky Chavez
  Physician Member: Appointed by the Chief of Staff

- Community Healthcare & Alliance Committee (CHAC)

Chairperson – Dr. Nina Chaya
Board Member – Gigi Gleason
Board Member – Adela Sanchez
Board Member Alternate – George Coulter

Chairperson Chavez requested that Director Chaya meet with Mr. Aaron Byzak and lay out an aggressive plan to ensure we are more active in the community than in the past.

Chairperson Chavez stated there is also an Ad hoc Committee comprised of Chairperson Leigh Anne Grass, Director Younger and Board Attorney Jeff Scott for the purpose of establishing the CEO Goals and Objectives.

Chairperson Chavez stated he took noted on the intent of the nurses related to patient care, health and safety and recruitment and retention and he looks forward to working together.

Director Grass reported the Ad Hoc Committee has completed their assignment with respect the establishment of the CEO's Goals and Objectives.

15. Move to adjourn

It was moved by Director Grass and seconded by Director Younger to adjourn the meeting. The motion passed unanimously (7-0) by a roll call vote.

16. There being no further business Chairperson Chavez adjourned the meeting at 4:15 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Tracy M. Younger, Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCMC Days in Accounts Receivable (A/R)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY21	51.1	50.9	52.7	50.7	50.9	50.7	55.4	54.6					52.1	48-52
FY20	52.8	56.4	59.2	61.2	61.9	62.6	61.5	58.7	53.1	50.5	56.4	55.3	59.3	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY21	107.1	103.1	101.1	99.6	99.6	92.7	93.9	94.6					99.0	75-100
FY20	93.0	89.9	90.8	98.4	92.8	85.5	88.5	94.3	88.9	97.3	105.5	108.0	91.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)					($3,027)	($8,062)
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)	($4,467)	$1,921	($2,982)	$170	($5,711)	

TCHD EROE % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY21	-6.12%	-3.74%	-3.60%	1.78%	-0.64%	-3.12%	4.13%	-0.92%					-1.42%	-3.94%
FY20	-1.65%	-1.66%	-2.71%	-1.08%	-3.91%	-3.75%	-2.85%	-2.69%	-17.32%	9.94%	-14.31%	0.69%	-2.51%	

57

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Financial Information

TCHD EBITDA $ in Thousands (Earnings before Interest, Taxes, Depreciation and Amortization)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935					$6,630	$ 1,337
FY20	$686	$681	$412	$683	$62	$128	$367	$551	($3,164)	$3,159	($1,774)	$1,383	$3,571	

TCHD EBITDA % of Total Operating Revenue

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY21	-0.78%	1.18%	1.17%	6.09%	3.22%	1.18%	8.73%	3.50%					3.12%	0.65%
FY20	2.38%	2.30%	1.47%	2.36%	0.24%	0.46%	1.22%	2.02%	-12.27%	16.35%	-8.51%	5.59%	1.57%	

TCMC Paid FTE (Full-Time Equivalent) per Adjusted Occupied Bed

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY21	5.38	5.66	5.40	5.87	5.25	5.75	5.10	5.61					5.49	6.37
FY20	7.04	6.80	6.21	6.90	6.58	6.44	6.71	6.82	7.02	7.27	5.61	5.51	6.69	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY21	$59.5	$57.4	$83.5	$76.9	$71.3	$68.5	$71.4	$75.4				
FY20	$52.4	$44.8	$43.7	$45.6	$38.2	$31.9	$35.2	$35.8	$34.8	$51.2	$62.3	$60.4

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending February 28, 2021

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)	48,472.27	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)	19,975.10	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
INVESTORS PROPERTY MGMT 2181 S El Camino Real, Suite 206 Oceanside, Ca 92054 V#81028	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	**OSNC 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	$2.59	(a)	3,754.00	02/01/20	02/28/21	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**$ 193,165.27**				

(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 February 2021

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	ENA Membership	021921	136.00	79163	NULTY, TAWNYA
8740	Life Support	021921	150.00	79442	SENERES CHRISTIAN
8740	NRP Course	020521 EDU	149.00	82852	KRUSSEL, SHIRLEY
8740	ACLS	021121 EDU	150.00	83455	CONDA, RUTH E
8740	ACLS	020521 EDU	200.00	83708	RODRIGUEZ MARIA DE

**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.